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LOADING PTOS FOR WINDOWS

Minimum Requirements:
IBM PC Compatible Computer
Windows 95, 98, 2000, XP or NT
64 Megabytes Memory (256 Meg Recommended)
Display capable of 600 by 800 resolution
Printer capable of 12 CPI printing

INSTALLATION INSTRUCTIONS – SINGLE USER

PTOS for Windows can be loaded into any folder on your computer. We recommend loading it into a folder named "VPTOS" on the "C" drive. This is the default in SETUP.

1. Place the CD in your drive. Depending on your configuration, the CD may install automatically. If not, click START on your desktop, then click RUN. Run SETUP from your CD drive. If your CD drive is "G:" for example, you will type G:SETUP in the "OPEN" box.

2. Follow the prompts through the several SETUP screens until you are prompted for the FOLDER in which to install PTOS. The default is C:\VPTOS. You can, however change both the drive and the folder for installation. We recommend keeping everything in C:\VPTOS unless you really have a reason to change it. Finally, click on INSTALL ALL FILES.

INSTALLATION INSTRUCTIONS – NETWORK

Network installation is similar to single user installation with a couple of additions. You will have two program CD's, one labeled SERVER and the other CLIENT. The SERVER CD should be loaded on the network server in the same manner described above for a single user installation. In most cases, the drive letter will be "F:". If installing PTOS on your network server from a work station, be sure to use the server drive letter.

The CLIENT CD should be loaded on each of the workstations. The default installation folder for clients is "C:\CPTOS". Once the initial installation of the workstation has taken place, run the CPTOS program from the icon on the menu. A Database Selector will ask you to enter the path to the data files on the server. We strongly recommend creating a map to the server on each workstation.

NOTES FOR CONVERSION FROM PTOS 2000:

- Inactive data will not be converted. If you have inactive Patients and Transactions that you wish to save, you should REINSTALL ALL INACTIVE accounts before converting.

- ARCHIVE OLD ACCOUNTS has been changed to REMOVE OLD ACCOUNTS. Once a patient has been discharged, their bills paid and statistics run, the account is permanently removed from the system as before. There is no longer a backup of ARCHIVED data on diskette.

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1. INTRODUCTION

Welcome to PTOS for WINDOWS. When you first sit down to learn the system, keep in mind that it will probably take four to six weeks for you to feel proficient. At first, it's totally new but soon, operation becomes second nature. Remember, we're always available at 1-800-824-4305 to answer your questions. Support hours are 6:00AM to 4:30PM Pacific Time, Monday through Friday.

TYPICAL PTOS ACTIVITY SEQUENCES
Before the specifics, let's OUTLINE the process of setting up PTOS and using it on a daily basis.

INITIAL SETUP
- SETUP YOUR SYSTEM - Details on how to set up the computer and load the PTOS program are found below.
- LEARN PTOS - Read the ENTIRE manual to learn how PTOS will work best for you.
- SET UP CODE FILES - There are several types of coded data, therapist codes, referring doctor codes, etc., that need to be set up.
- CHANGE PARAMETERS - These are options that let you tailor PTOS to your office.

DAILY ROUTINES
- ENTER PATIENT DATA - Enter new patients and modify existing information.
- UPDATE PATIENT SCHEDULES - If you use the scheduling option in PTOS.
- ENTER DAILY TRANSACTIONS - Post new charges, payments, and adjustments.
- PRINT BANK DEPOSIT SLIP - If you use PTOS to generate your bank deposit slip.
- PRINT DAILY TRANSACTION REPORT - This is your key audit list of what was posted.
- BACKUP FILES - Backing up data files is EXTREMELY IMPORTANT. Back up files DAILY.

WEELY ROUTINES
- PRINT PATIENT AND INSURANCE BILLS - These can be printed more or less frequently than once a week as desired.
- RESET FILES - This reorganizes data files into their most efficient layout.

MONTHLY ROUTINES
- PREPARE AND PRINT AGED ACCOUNTS RECEIVABLE - This tracks the efficiency of billing and collections, and is key in verifying that accounts are in balance.
- PRINT "PATIENT NUMBER LIST" - This is also used in account balancing.
- PRINT COLLECTION ANALYSIS REPORT - Along with aged A/R and the Patient Number List, this is used in balancing account totals.
- PRINT ANY OTHER DESIRED MANAGEMENT REPORTS - There are some, but probably not all, reports that you want to see on a monthly basis.
- PRINT ANY OTHER DESIRED LISTS - As referring doctor, account type or other codes are added to your system, print updated reference lists
- REMOVE OLD ACCOUNTS FROM THE SYSTEM - When a patient is no longer active, they can be permanently removed. Once removed, their data can no longer be accessed.
- PRINT NEW"PATIENT NUMBER LIST" - If accounts have been REMOVED, print a new copy of the list to use in balancing accounts.

This is an outline of how PTOS will be used. Keeping this flow in mind as you learn about PTOS will help bring the entire picture together.

COMPUTER SETUP

PTOS is a VISUAL FOX PRO application program designed to run under Windows 95 or higher on IBM compatible PCs.

MEMORY – We recommend a minimum of 64 megabytes of memory. 128 megabytes is better and 256 megabytes is optimal.

DISPLAY - PTOS for Windows requires a monitor with a resolution of 800 by 600 or higher.

PRINTERS - Selecting a printer is critical for achieving the best results. We recommend LASER printers. All PTOS output is formatted for 12 characters-per-inch printing and alignment must be set carefully, especially for insurance claims. Other requirements are that the printer be set for 11 inch paper, 6 lines per inch printing. Different printers accomplish setting these parameters in different ways. There are hundreds of printers on the market. We simply can't keep up with all the changing commands for manipulating printers and we do not provide printer drivers. It is the responsibility of the person who sold you the printer to show you how to set it up.

LOCAL AREA NETWORKS

If you will be running PTOS on a network, there are several considerations to keep in mind. First, you MUST have a Network version of PTOS. With the Network version of PTOS, you receive an addendum that details the setup and operational considerations to follow.

PTOS requires **FULL RIGHTS** to the VPTOS folder and all of its sub-folders and files. In addition, all workstations must have FULL RIGHTS to their local TEMP folder and its files.

You can direct printing to any printer on the network by selecting PRINTER DIRECTION from CHANGE PARAMETERS in SYSTEM TASKS. Printing can also be redirected at the time sending output to a printer is selected. If you use print spooling, it is up to your hardware consultant to set the spooler correctly. If this is not set correctly, documents can be lost.

OPERATIONAL CONSIDERATIONS -The Network version of PTOS allows a high degree of freedom when using various data entry and reporting routines. As with any multi-station data entry system, however, certain precautions should be taken into consideration. These considerations can be summed up in one statement: "No data can be entered that will affect the results of another operation taking place at that same time". Specific considerations are listed below.

RESET FILES - When one workstation is resetting files, all other workstations must first select the CLOSE ALL FILES task from the SYSTEMS TASKS menu bar. Once reset has completed, they can click on "OK" to reopen files and continue using PTOS.

IMPORTANT INFORMATION

There are basics which apply throughout PTOS which you should take note of. THESE ARE ALL IMPORTANT AND MUST BE FOLLOWED.

FORMAT FOR DATES - There are four different formats you can select to enter dates. These are explained in the CHANGE PARAMETERS section. Once you select a format, all dates must be entered the same way. NOTE: This is only for entering data and will not affect printing of reports or lists.

SHORTCUT KEYS - Many options have shortcut keys. These are underlined letters that call the option just as though you had clicked the entry with your mouse. To select PATIENT DATA from the task bar, for example hold down the ALT key and press " P"

CANCEL PRINT
If you have sent output to your printer, whether a report, insurance claim or other output, you can cancel the print job by pressing the **ESCAPE KEY <ESC>.** Note that if you have a print spooler or a large print buffer, output already sent to the printer will continue to print.

INSERTING VS OVERTYPING - When you type data into a field it will normally overtype (replace) what is already there. You can use the cursor arrow keys to move to exactly where you want to be when overtyping. If you wish to insert something, rather than overtype, press "insert" key on your keyboard. Press it again to go back to the overtype mode.

When typing data into a field, press <tab> or <enter> when you are finished. This tells PTOS to move to the next field. If you fill a field PTOS will know you are finished when the last character is filled and will move to the next field.

There are three "delete" keys that you can use when entering data.

CTRL + G - deletes a character
CTRL + T - deletes a word
CTRL + Y - deletes the REST of the field

STOPPING THE SYSTEM - NEVER TURN OFF THE COMPUTER WHEN IT'S RUNNING A TASK. End a session by selecting "END" from the task bar.

MESSAGES - you will frequently see messages on the screen. They provide information about an action to be taken. These guide you through various tasks. A message may contain options such as "C)ontinue or E)nd". Type the first letter of the word describing the desired selection. In the above example, by pressing "C" the task will continue to process, pressing "E" will end it.

UPPER VS. LOWER CASE - You must be consistent when using upper and lower case letters. PTOS takes what you type literally, for example John Doe and JOHN DOE are two different people as far as PTOS is concerned.

LIST BOXES - PTOS uses many "code" fields to make data entry faster and more accurate. All code fields can access a LIST BOX. When you are in a code field, double click the mouse or press the "F2" key. Let's say you are entering a new patient and want to pull in insurance carrier data. With the cursor in the PRIMARY INSURANCE box, double click and PTOS will list all insurance carriers in the system. If you're only interested in "BLUE CROSS", PTOS can list only Blue Cross plans in the system.

You can move up and down through the list using the arrow button or sliding bar on the right of the list. When you find the entry to select , left click it with the mouse and the appropriate insurance information is automatically filled into the patient file. If you don't want to pull in any of the entries you see, right click the mouse. **NOTE: WHEN RIGHT CLICKING TO CLOSE A LIST BOX, THE MOUSE POINTER MUST BE OVER THE DATA CONTAINED IN THE LIST BOX, IT CAN NOT BE OVER A WHITE AREA IN THE BOX.**

SYSTEM DESCRIPTION
Most of the time you spend with PTOS will be entering and reviewing information in data files. Here are three definitions to remember:

FILES are where your information is stored. For example, the Patient Data File contains all information about patients, such as name, address, and balance due.

A RECORD is a collection of related words or data that make up one entry in the file. A record in the patient data file contains all information about one patient.

A FIELD is a specific piece of data in a record. "First Name" is a field in the patient data file.

LEARNING PTOS
Read each section of the manual and perform tasks as you read about them. Type in fictitious patient information and "play" with the data. Don't be afraid to make mistakes; everything you do during training can be deleted before you start using PTOS for real work.

PTOS has been developed for all sizes and types of therapy clinics. Don't think that you must use every feature, option, list and report to get the most out of the program. Read about all the features but don't feel that you must understand and start using every option to be efficient.

TELEPHONE TRAINING SESSIONS
APS has developed a series of one hour phone training modules to make learning PTOS even easier. You can purchase individual beginning or advanced modules, or a package of several introductory modules. Call the APS Support line for more information.

SEMINARS
APS continually offers basic and advanced training seminars across the country. These help you learn PTOS as a new user, and gain additional expertise as you become familiar with the system. For more information, call the APS Support line.

STARTING PTOS

If you have set up an ICON for PTOS, just click on it. Otherwise, select "VPTOS" from the PROGRAMS list. The system first asks for **"System Date"**. This can be different from the actual date. If today is February 3rd, and you are still inputting data and running reports for January, you can type a system date of January 31.

USER ID
After entering a valid date, PTOS asks for your User ID. When you first receive PTOS there are no user ID's set, you can just press <enter> to proceed. The office manager should select CHANGE PARAMETERS in SYSTEM TASKS to create user ID's and password levels. This process is explained in CHANGE PARAMETERS.

The TASK BAR below is displayed showing options which you can select. Each of the selections will be covered in detail in the following sections.

Patient Data Transactions Billing Reports Patient Lists Other Lists System Tasks Special Tasks

UPDATE CODES

When you install PTOS, the first step is entering various **"codes"** including procedure, diagnosis and insurance codes. Using codes will save you a lot of typing. For example, on the insurance billing form you need to show the patient's diagnosis. This diagnosis is entered in the Patient Data File, which is described in a later section. Instead of typing a description like **"SHOULDER SPRAIN OR STRAIN",** you can just type the code **"840",** and the appropriate description is automatically filled in. Creating codes is found under "SYSTEM TASKS" . Click on the SYSTEM TASKS bar or type ALT + "S". Then select UPDATE CODES.

UPDATES CODES

ICD9 Codes
Insurance Carrier
Referral Sources
Procedure Codes
Therapist Codes
Payment/Adjustment Codes
City Codes
Account Type Codes
Employer Codes

UPDATE ICD9 CODES
PTOS comes to you with a set of diagnosis codes. You can revise or add to the standard list by selecting UPDATE ICD9 CODES. Print a list of the existing codes through the **OTHER LISTS** menu to see what's already in the system, and see which you want to add or change.

To modify or add a code, select UPDATE ICD9 CODES, and type the code. You can also double click to list codes already in the system. You can add new codes or modify any existing field except the code itself. If you change the description of an existing ICD9 code, PTOS will ask if you want the description to be automatically updated into all patient records that contain the ICD9 code. If you fill in the number of allowed visits and the duration of treatment days, PTOS will track patients that are approaching the authorized maximum.

To delete an existing code, click on the "DELETE" button; to add or change other codes click on "QUIT" to return to the previous screen.

***** NOTE *** THIS SEQUENCE OF ENTRY APPLIES TO ADDING, DELETING OR REVISING ANY TYPE OF PTOS CODE.**

UPDATE INSURANCE CARRIERS
In most cases a patient will be covered by one or more insurance carriers. PTOS allows you to enter the carrier's name and address information once, assigning a four digit code to the carrier.

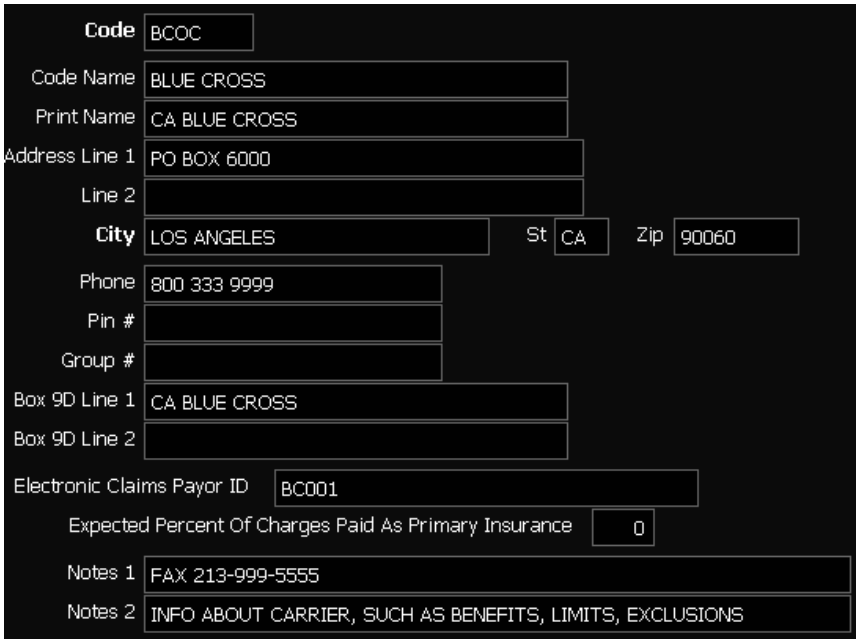
When billing, PTOS links the codes you've entered in the Patient Data File with the name and address information you have entered in the Insurance Carrier File. The appropriate sections of the insurance claim are then filled in. When assigning insurance codes for the first time, it's best to sit down with a list of all the carriers you normally deal with and assign codes to each. The codes can be characters and/or numbers and should be meaningful to you.

The code has a **"CODE NAME"** to indicate the specific carrier name and address. For example, you may deal with several Blue Cross plans with different addresses. They could be designated

"BCGM", "BCSE", etc. When you're entering patient data and aren't sure of the right insurance code, you can double click to list all carriers with a similar CODE NAME.

To add or revise insurance carrier information, select UPDATE INSURANCE CARRIERS. Then type the insurance code. PTOS will search to see if that code already exists. If it's a new code, PTOS will tell you and you can add the code, quit, or find another code. The screen below shows the layout for entering insurance carriers.

BEFORE CREATING INSURANCE CODES, READ THE SECTION ON BILLING CODE TRANSLATION UNDER UPDATE PROCEDURE CODES.



The CODE NAME is only used as a reference to you. The PRINT NAME is what will actually print on the billing form, along with the address. ***** NOTE: CITY is a "code" field.** You can press F2 to list all available cities or you can enter a three digit code. This works the same with all "CITY" fields in PTOS. CITY CODE creation is described below.

The PHONE NUMBER will be automatically referenced on the PATIENT DATA SCREEN as an additional aid for insurance follow-up. The address layout in BOX 9D will print on the HCFA-1500 as well as PIN# and GROUP#.

The ELECTRONIC CLAIMS PAYOR ID is used by some clearinghouses to transmit electronic insurance claims. If you purchase a separate ECS module from APS, necessary codes will be supplied by the appropriate clearinghouse. There are also two note fields for any information you need to enter. If you wish to change Insurance codes once they've been created, see RENUMBER ACCOUNTS under SPECIAL TASKS.

UPDATE REFERRAL CODES

Referral codes can represent physicians or attorneys. A Referral Code can be up to five characters. You can DOUBLE CLICK OR USE THE F2 key to list existing referral sources. If the code is new, PTOS asks if you want to ADD, and a screen like the one below appears.

The PRINT NAME is what appears on the billing forms and various reports. It should be entered Last name and First name, as in the above example. This way, physicians will print in the proper alphabetical order on reports.

If you revise a PRINT NAME for a referring doctor, PTOS will ask if you want to automatically make the same change for all patients with that referral source. FIRST NAME, LAST NAME, TITLE and the three ADDRESS lines are used so that you can send letters as explained in the SEND LETTERS option of SPECIAL TASKS.

SPECIALTY is used so that you may send letters to specific groups of doctors, such as all neurologists, or all orthopedic surgeons.

PROCEDURE CODES
When a patient comes in for treatment, a charge, or transaction as we call it, is posted to the patient's account. This transaction details exactly what was done, for example; **"Hot Packs, Ultrasound, Massage".** You can type the description and charge each time, or you can eliminate all the repetitive typing by using procedure codes.

Using PROCEDURE CODES is one of the biggest time-savers in PTOS. Since every office has it's unique charges and even different descriptions of various procedures, we've found that a standard set of procedure codes just doesn't work; you need to create your own.

BILLING CODE TRANSLATION
It is becoming more and more common for the patient's primary insurance to use one type of coding system, such as RVS, and the secondary carrier to use something different, such as CPT. We have incorporated a feature called BILLING CODE TRANSLATION that makes translation to the appropriate coding automatic. If one or more of the following cases apply to you, BILLING CODE TRANSLATION may be a solution:

1. Do you have different insurance carriers that require different CPT/RVS codes on HCFA-1500 or UB92 forms for the same procedure?
2. Do you have different fee schedules for different types of insurance coverage?
3. Do you want to track different EXPECTED PAYMENT amounts from various insurance carriers, i.e. the expected payment from Medicare is different than from Work-Comp?

To use Billing Code Translation, first select CHANGE PARAMETERS from the SYSTEM TASKS menu, then select BILLING CODE TRANSLATION. For the translation to work, the following coding rules MUST be followed.

THE FOLLOWING ONLY APPLIES IF BILLING CODE TRANSLATION IS USED: The first character of the procedure code MUST indicate the coding type. **"RHUM"** could describe Hot packs, Ultrasound, Massage using RVS codes while **"CHUM"** could describe the same visit using CPT codes. You may also have **"BHUM"** if you were using special codes for Blue Cross, or any other coding systems.

When you establish **insurance codes**, the first digit of the code MUST correspond to the procedure code type. Let's say Prudential wanted RVS codes. The code for Prudential would have to start with an **"R"**, such as **"RPRU"**. If Metropolitan wanted CPT codes used, their insurance code would start with a **"C"** such as **"CMET"**.

When you post the transaction, don't include the first digit of the procedure code (the character that describes the coding type). In our above example, just post **"HUM"**. PTOS will know that if the first digit of the primary insurance is **"R"**, an **"RHUM"** should be posted to the account. If the primary carrier was Metropolitan, posting **"HUM"** would cause **"CHUM"** to be posted to the patient account.

If a patient has **"RPRU"** as primary carrier and **"CMET"** as secondary; when the primary insurance is billed, the **"RHUM"** code will be printed on the HCFA-1500 billing form, and the **"CHUM"** code printed when the secondary is billed. If you already have established Insurance codes, and wish to change them, see RENUMBER ACCOUNTS under SPECIAL TASKS.

NOTE: "Z" codes are NOT translated. Also, PROCEDURE CODES to be translated MUST be at least 3 characters.

UPDATE PROCEDURE CODES

You are now ready to lay out the combinations of individual procedures that you will commonly use. The unusual combinations used infrequently can be ignored. Now assign PROCEDURE CODES of up to five digits to each.

SAMPLE PROCEDURE CODES

HP1 - Hot Packs 15 min.
HTX1 - Hot Packs 15 min, Ther Ex 15 min.
HTX2 - Hot Packs 15 min, Ther Ex 30 min.
HTX3 - Hot Packs 15 min, Ther Ex 45 min.
HTX1 - Hot Packs 15 min, Ther Ex 15 min, Traction 15 min.
HTX2 - Hot Packs 15 min, Ther Ex 30 min, Traction 15 min.
HTX3 - Hot Packs 15 min, Ther Ex 30 min, Traction 30 min.

****

Important : IF YOUR OFFICE IS A CERTIFIED REHABILITATION AGENCY AND YOU WILL USE THE UB92 FORM TO BILL MEDICARE, ALL PROCEDURE CODES MUST START WITH ONE OF THE FOLLOWING NUMBERS TO GET THE PROPER REVENUE CODES ON YOUR BILLING:

1 = Physical Therapy Visit	4 = Speech Therapy Evaluation
2 = Physical Therapy Evaluation	5 = Occupational Therapy Visit
3 = Speech Therapy Visit	6 = Occupational Therapy Evaluation

For example **"Hot Packs 15 min, Ther Ex 45 min."** would be 1HTX3 instead of HTX3. If you offer other services, and use other codes, such as Nursing Services or Psychological Services, call the Support Center for assistance in assigning codes to this services.

If you will use BILLING CODE TRANSLATION, the first digit of the Procedure code must correspond to the insurance carrier code, as described in the section BILLING CODE TRANSLATION. The second digit of the code must use one of the numbers listed above, such as "1" for PT visit.
****

Notice that in our table of PROCEDURE CODES above, there is an individual entry for Hot Packs. This is for times you may have an unusual combination of treatment, such as Hot Packs and Biofeedback, which you haven't set up a combination PROCEDURE CODE for. You can then post two individual codes (HP1 and BF1 for example). This is explained in detail in the section on Entering Transactions.

There is a **"Special"** type of PROCEDURE CODE, called a **"Z"** code. When you post transactions, PTOS will count how many patients were treated. This total is tracked in VISITS on the various productivity reports. If you sell supply items, such as weights or bandages, you don't want to count them as visits. When you post a transaction, PTOS will ask if it should count it as a visit. However, if you have some codes that will NEVER count as visits, the code should start with a **"Z"**. This will automatically mark it as **"Count As Visit" = No** when you post the entry.

To define a procedure, select UPDATE PROCEDURE CODES. Type the code you wish to assign. The system checks to see if it has already been used. If it has been created, PTOS displays the procedure and it can be revised.

RVS/CPT - You may enter an RVS, CPT, or other code of up to eleven digits. The first five digits print in BOX 24D of the HCFA-1500 form, and the last six as the Modifier in 24D. If you bill on the UB92 and select the "Line Item" format, the first five digits print in Box 44 and the last six digits can print in Box 42 or as a modifier in Box 44. These options are described in the INSURANCE BILLING section.

DESCRIPTION - There can be 25 characters under each description line which corresponds to spacing on many insurance forms. On the 12/90 version of the HFCA-1500 form however, there is only room for the first six characters. Normally, nothing in the description field will print on the HFCA-1500, you can, however, select printing these first six characters when running the billing option. **THERE CAN BE NO BLANK LINES WITHIN THE DESCRIPTION. WHEN PRINTING BILLS IF PTOS SEES A BLANK LINE, IT THINKS THE END OF THE DESCRIPTION HAS BEEN REACHED, AND BILLING WILL BE INACCURATE.**

UNITS - If units are entered, they will print on the HCFA form in Box 24G.

AMOUNT - The final part of each description line is the fee.

OLD AMT – If you change fees, PTOS will track and show the LAST previous charge.

THE "STATEMENT DESCRIPTION" IS PRINTED ON THE PATIENT STATEMENT.

CO-PAY - In most cases, CO-PAY will vary by account type. It can therefore be established in the UPDATE ACCOUNT TYPES as described below, or even modified for an individual patient. You also have the option of entering CO-PAY in the procedure code if it will not vary by account type. When you enter data for a new patient, you tell PTOS whether to use co-pay billing. This is explained later in the section on entering Patient Data.

TOS - is the abbreviation for Type Of Service used in Box 24C of the HFCA-1500.

COST – If you wish to calculate the profitability of individual procedures, you can enter an amount here that reflects the cost of delivering the treatment. PTOS will track it on your PROCEDURE SUMMARY REPORT.

TIME – Entering the time it takes to perform the procedure will allow total treatment time to be calculated on your PROCEDURE SUMMARY REPORT.

EXPECTED AMOUNT - The amount billed is usually not what you really expect to receive for the visit. By entering the expected amount here, you can track the amounts you expect to receive from third party payors.

BILL TO PATIENT OR SECONDARY INSURANCE ONLY - In most cases, all charges are billed to all parties. There may be certain charges that you don't want to bill to some insurance carriers. Enter a "P" in this field and the procedure code will only be billed to the patient. If you want the secondary insurance and the patient but not the primary to be billed, enter an "S".

REVISING A PROCEDURE

Once defined, any part of a PROCEDURE CODE can be revised except the code itself. Also, you can not decrease or increase the total number of description lines. If you have a code with a three line description, don't edit the wording to create a two line description. Instead, create a new code with the two line description. If you change the number of description lines, your insurance claims will not print properly.

If during editing TOTAL AMOUNT of the fee changes, PTOS will warn you. **NOTE - The new fee takes effect the day after the SYSTEM DATE, so make sure you entered the correct SYSTEM DATE when you start PTOS.**

When changing fees, consider how it will affect transactions. If the procedure has been posted to some accounts using one fee, and you then change the total fee, PTOS will keep track of the DATE OF FEE CHANGE and the PREVIOUS AMOUNT. When generating bills or calculating financial data, PTOS will look at what fee was in effect on the posting date.

PTOS TRACKS TWO FEE CHANGES. Let's say you have a procedure with fee of $40. On January 1, 2004 it will change to $50, and on June 1, 2004 it was changed to $60. It is again changed to $70 on January 1, 2005. PTOS shows the current amount as $70, the LAST FEE as $60, and PRIOR FEE as $50. If you rebill a December 2003 charge on an INSURANCE FORM, or on a DETAILED PATIENT STATEMENT, PTOS will bill the charge as $50 even though the fee in effect the day it was originally posted was $40. This does not apply to billing on a SUMMARY PATIENT STATEMENT, as the summary patient statement does not use the procedure code information when billing. For more detailed explanation of billing options, see PATIENT OR INSURANCE BILLING.

If you need to make several changes to a fee on a given procedure over a short period of time, and anticipate that this may affect billing, instead of changing the old fee, copy the procedure to a new code and change the fee of the new code.

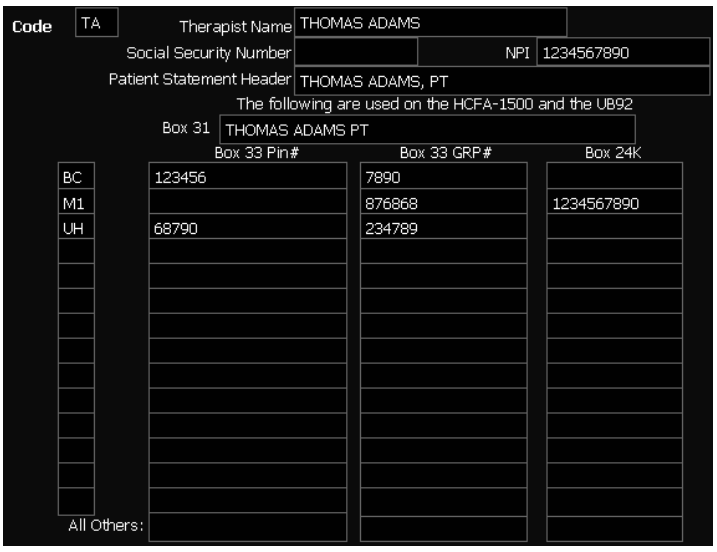
COPYING A PROCEDURE
If you wish to create another code similar to one that already exists, as in the above example of HTX2 and HTX3, you can copy an existing code to a new code. First, pull up the PROCEDURE CODE you want to copy FROM and click the COPY button. PTOS will ask for the new code to copy to. You can then revise the new PROCEDURE CODE .

DELETING A PROCEDURE CODE
Sometimes you'll find there are procedure codes you no longer need. These can be deleted, however there are some considerations. If you have posted transactions with the code you wish to delete, you will no longer be able to print insurance claims containing transactions posted with that code. You should print PROCEDURE by LAST DATE USED in OTHER LISTS before deleting codes.

MILEAGE CODES
If you bill for mileage, primarily for a contract or home health, there is a special type of procedure code that will automatically calculate the fee. Mileage codes must begin with **"ZMI"**. Enter the description as you would for any code, with the amount being the PER MILE FEE. For example you could have a code **"ZMIH"** and an amount of $ .35 for a home health mileage charge of 35 cents per mile, and another code **"ZMIC"** with an amount of $ .37 per mile for another contract. When you post the procedure code to an account, enter the number of miles driven in the field that is normally used to enter the diagnosis code (see Enter Transactions). PTOS will multiply the miles driven by the per mile charge and post this to the patient's account.

Creating PROCEDURE CODES needs to be well thought out. They are the most complex part of setting up your PTOS system, and will be one of your biggest time-savers when in place.

UPDATE THERAPIST CODES
This allows you to assign a two digit code for each therapist. The therapist code appears on several lists and reports and can also be used to show the name and provider number of the treating therapist on patient and insurance billings. On the HCFA-1500, there are several references to the treating therapist. These are Boxes 24K, 31 and 33. If you wish PTOS to automatically fill out these boxes, you can enter the information here**. NOTE – A THERAPIST MUST BE ENTERED HERE BEFORE THEIR CODE CAN BE ASSIGNED TO NEW PATIENTS.**

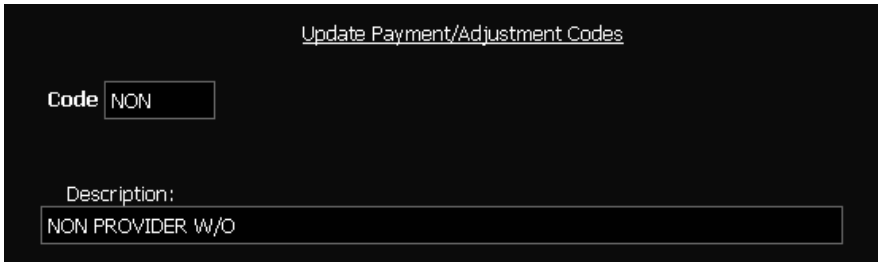


NPI #: The NPI number will print in box 32b and 33b on the HCFA 2007 form.

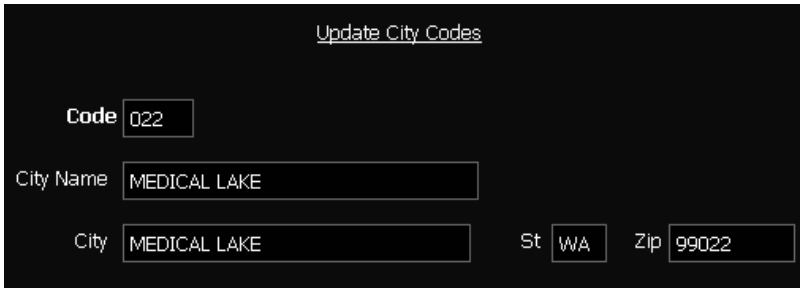
Frequently a therapist will have different PIN or GRP numbers for various account types. By filling out the PIN, GROUP and Box 24K numbers, along with the account type, the appropriate numbers will be used when printing HCFA forms. ******NOTE*** If you have filled in the PIN and/or GRP numbers under INSURANCE CODES, the therapist's PIN and/or GRP numbers will override the insurance numbers.**

If you want the assigned therapist's name to appear as part of the header on the PATIENT STATEMENT, fill in the therapist's name in the PATIENT STATEMENT HEADER field.

UPDATE PAYMENT/ADJUSTMENT CODES
Different types of payments, and credit and debit adjustments to patient accounts are described in detail in ENTER OR ADJUST TRANSACTIONS. When you post a payment or adjustment, you can type the description each time, or set up standard PAYMENT/ADJUSTMENT CODES. If descriptions like "Blue Cross Payment" will be used over and over, just create a code **"BCP"**. A sample entry for a **"Blue Cross Payment"** is shown below. This will also allow you to run a LIST OF TRANSACTIONS to see how much was received or written off for that description during any given time period.

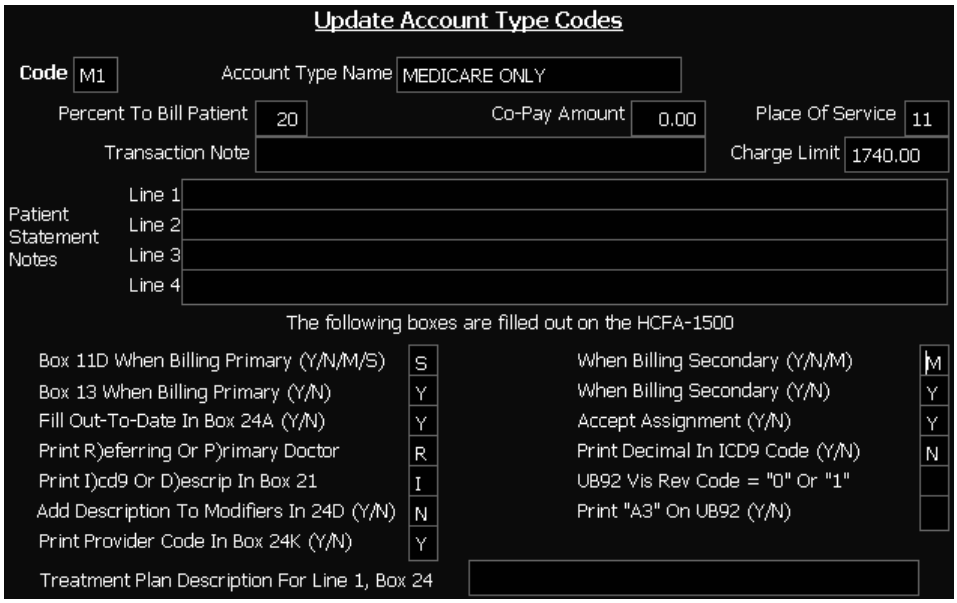


UPDATE CITY CODES
You probably use the same city, state and zip code in the address of many patients, referring doctors, attorneys and payors. Instead of typing the same information over and over, you can create CITY CODES. We recommend using the last three digits of ZIP CODE as this will usually be unique. By entering a CITY CODE like "031" you can create a standard city as shown below.



Now, whenever PTOS asks for a city, type the code, or DOUBLE CLICK or use the F2 key to find the appropriate city.

UPDATE ACCOUNT TYPES
All patients within the same account type will have certain standard requirements. By creating ACCOUNT TYPE CODES, you tell PTOS the billing profile for each account type.


Update Account Type Codes
Code M1
Account Type Name MEDICARE ONLY
Percent To Bill Patient 20
Co-Pay Amount 0.00
Place Of Service 11
Transaction Note
Charge Limit 1740.00
Patient Statement Notes
Line 1
Line 2
Line 3
Line 4
The following boxes are filled out on the HCFA-1500
Box 11D When Billing Primary (Y/N/M/S) S
When Billing Secondary (Y/N/M) M
Box 13 When Billing Primary (Y/N) Y
When Billing Secondary (Y/N) Y
Fill Out-To-Date In Box 24A (Y/N) Y
Accept Assignment (Y/N) Y
Print R)eferring Or P)rimary Doctor R
Print Decimal In ICD9 Code (Y/N) N
Print I)cd9 Or D)escrip In Box 21 I
UB92 Vis Rev Code = "0" Or "1"
Add Description To Modifiers In 24D (Y/N) N
Print "A3" On UB92 (Y/N)
Print Provider Code In Box 24K (Y/N) Y
Treatment Plan Description For Line 1, Box 24

The PERCENT TO BILL PATIENT, COPAY AMOUNT, PLACE OF SERVICE, TRANSACTION NOTE, CHARGE/CAP LIMIT and ACCEPT ASSIGNMENT are automatically pulled into a patient's record when you indicate the patient's account type on the first page of PATIENT DATA ENTRY. PATIENT STATEMENT NOTES will be printed at the bottom of the patient's billing statement. The other parameters on this screen determine how the HCFA-1500 form is printed.

PERCENT TO BILL PATIENT
If insurance for this account type pay 80% of charges, enter 20 here for the patient responsibility.

CO-PAY
If all patients within this account type have a set co-pay amount, enter it here.

TRANSACTION NOTE
This short description will appear on the TRANSACTION ENTRY screen as a reminder.

CHARGE LIMIT
If any payor limits charges for the patient or is using a CAP amount, enter that amount here. It will appear on the transaction screen as a reminder. If a new fiscal year starts, you can add the new year's CHARGE LIMIT to the old charge limit to continue tracking.

HCFA-1500 PARAMETERS
BOX11D WHEN BILLING PRIMARY or SECONDARY - You may want to suppress secondary insurance data. Placing "N" here suppresses boxes 9 through 9D. Medicare has requested a special format. If you select "M" for Medicare as primary, primary insurance data will print in boxes 4, 7, and 11. 11D will be checked NO and BOX 9 will be filled out. If you select "M" for Medicare as secondary, primary insurance data will print in boxes 4, 7, and 11. 11D will be checked YES, and all of BOX 9 will be blank. If you bill Medicare as PRIMARY, you may need to use the "S" option which prints "NONE" in Box 11 and leaves other insurance boxes blank.

BOX 13
If you do not want "SIGNATURE ON FILE" to print in box 13, answer NO.

FILL OUT -TO- DATE IN BOX 24A (Y/N)

Some carriers request that both FROM and TO dates be filled out in BOX 24A (even though the date is the same). Answering yes determines whether the "TO" portion of the box is filled out.

ACCEPT ASSIGNMENT
This determines how BOX 27 of the HCFA will be checked.

PRINT R)EFERRING OR P)RIMARY DOCTOR
The default for BOX 17 of the HCFA-1500 is referring doctor, but some insurance types, especially HMO's, may require the primary care physician.

PRINT I)CD9 OR D)ESCRIP IN BOX 21
On the HCFA-1500, the standard format is to print the ICD9 code rather than a descriptive diagnosis. If you want to print the description for this account type, enter "D" here.

PRINT DECIMAL IN ICD9 CODE(Y/N)
Normally, a decimal in the ICD9 code will print on the HCFA form. You can suppress it for an account type by selecting "N" here.

ADD DESCRIP TO MODIFIER IN 24D(Y/N)
There are six spaces after the modifier in BOX24D. If you enter "YES", the first six characters of the procedure description will print.

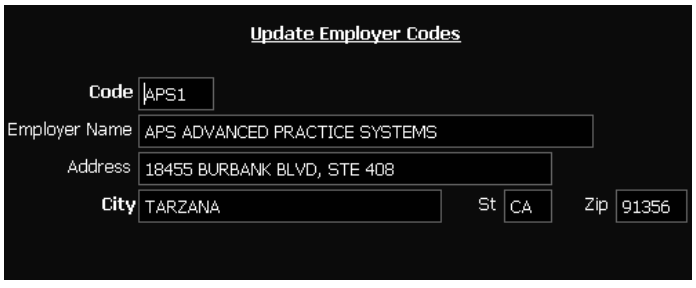
PRINT PROVIDER CODE IN BOX 24K
Sometimes treating therapist PIN numbers should be printed in BOX 24K of the HCFA-1500. This can be specified here by entering "Y".

TREATMENT PLAN DESCRIPTION FOR LINE 1, BOX24
Some account types require a description such as "PLAN OF TREATMENT ON FILE" to print on the insurance form. Enter an appropriate description here or leave the line blank if no description is needed.

UB92 VISIT REVENUE CODE
This and "A3" below apply only to Certified Rehab Agencies. When billing on the UB92, some intermediaries require treatment codes to end with "0", other intermediaries require a "1", for example, 420 or 421 are used as physical therapy treatment codes. Depending on the account type, this parameter allows you to control the codes printing on the UB92.

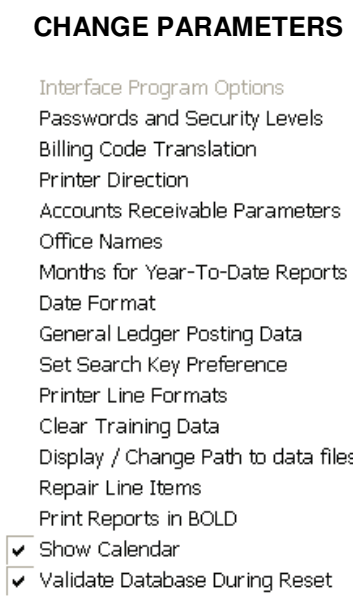
PRINT "A3" ON THE UB92
This value code prints in box 39 through 41 of the UB92 and is required by some but not all intermediaries. You can control its printing by account type.

UPDATE EMPLOYER CODES
Instead of typing the same employer name and address information over and over, you can create a library of frequently used employers. When you enter a four digit employer code, the following screen allows employer data to be entered.



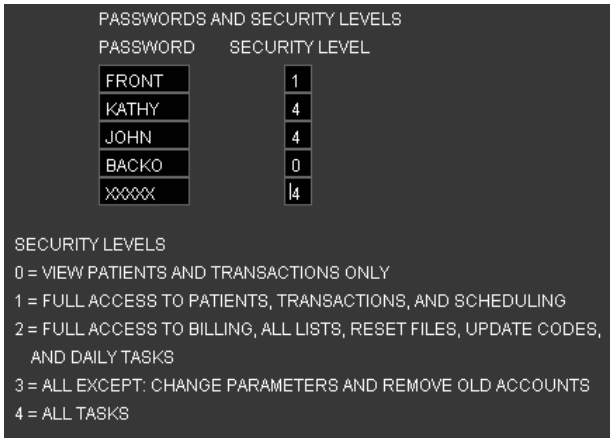
CHANGE PARAMETERS

Once code files are established, you will tailor PTOS by setting System Parameters. Select CHANGE PARAMETERS from the SYSTEM TASKS menu and the following appears.



INTERFACE PROGRAM OPTIONS
If you use Spectrasoft software for scheduling, or one of several popular documentation systems, they can be interfaced directly to PTOS with this option. You will only have this option if you have the PTOS interfaced version supplied by APS.

PASSWORDS AND SECURITY LEVELS
Not everyone on the staff needs to have access to all PTOS options. By selecting this option, you determine who has access to which tasks.



It is important that all passwords be filled out. If you leave one blank, anyone who signs on with a blank password can access the system.

USER ID
At startup, PTOS asks for a USER ID. There are 5 password settings, but you may have a dozen or more users who need access to PTOS. Everyone should be assigned a five-digit password that corresponds to their security level. In addition, each person is assigned a two digit suffix. In this way, several people can share the same password level. You do not need to enter the two digit suffix in PTOS, only the five standard passwords

Debbie = XXXXXDB Sally = XXXXXSA Bob = XXXXXBO

When you start PTOS and enter your USER ID, enter the five digit password, followed by your two digit ID. This will be automatically entered when transactions are posted and when patient notes are entered for data entry tracking.

BILLING CODE TRANSLATION
This is covered in UPDATE PROCEDURE CODES. To turn the feature on, type "Y" here.

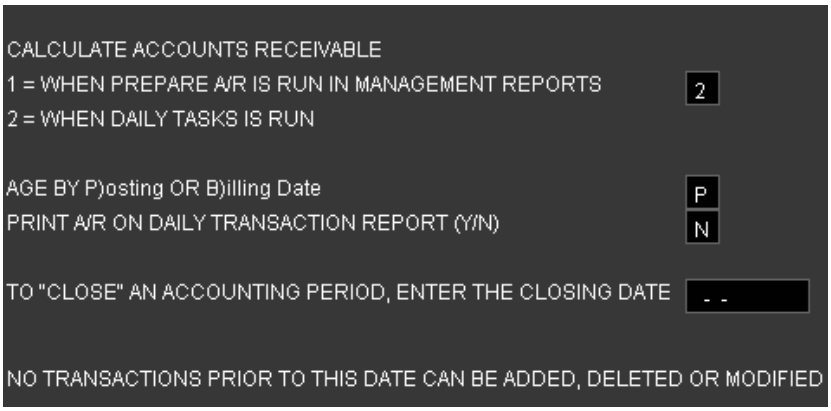
PRINTER DIRECTION
In most cases, you will use LPT1, which is the PTOS Default. You can, however, re-direct your printer, either permanently or for a temporary print run, by selecting this option.

When selected, the line below appears. You can enter the appropriate code for printer direction, INCLUDING AN ASCII FILE, SUCH AS REP1.TXT FOR A MANAGEMENT REPORT. You can then pull up the resulting file, i.e. REP1.TXT, to view or edit with a word processing program.

ACCOUNTS RECEIVABLE PARAMETERS
You are able to set several parameters for calculating accounts receivable. Normally, accounts are updated when transactions are entered, and completely re-aged when PREPARE ACCOUNTS RECEIVABLE is run in MANAGEMENT REPORTS. If you wish, any patient who had activity during the day can have their account completely re-aged when the DAILY TRANSACTION REPORT is printed.
The PTOS standard is to age accounts from the day a charge is posted. If you wish, you can change the setting so that aging will not start until the INSURANCE CARRIER is billed.

You can tell the system to print the A/R on the DAILY TRANSACTION REPORT. Then each time the report is run, PTOS will recalculate A/R, show the old A/R (not including activity on the report), the net change on the report, and the new A/R. If there is a difference (indicating a discrepancy in the data) then the difference will also print. You can also "close" an accounting period. No transactions prior to the closing date can be added, modified or deleted.

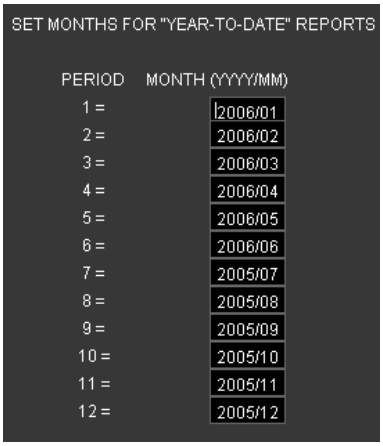
ACCOUNTS RECEIVABLE PARAMETERS


CALCULATE ACCOUNTS RECEIVABLE
1 = WHEN PREPARE A/R IS RUN IN MANAGEMENT REPORTS
2 = WHEN DAILY TASKS IS RUN
2
AGE BY P)osting OR B)illing Date
P
PRINT A/R ON DAILY TRANSACTION REPORT (Y/N)
N
TO "CLOSE" AN ACCOUNTING PERIOD, ENTER THE CLOSING DATE
- -
NO TRANSACTIONS PRIOR TO THIS DATE CAN BE ADDED, DELETED OR MODIFIED

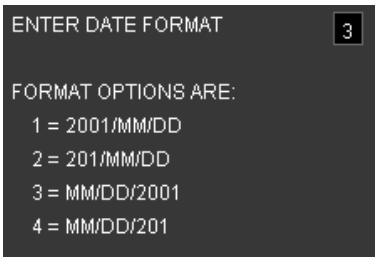
ENTER OFFICE NAMES

If yours is a multi-office practice, you are able to enter an office number in the patient account, showing where the patient is being treated. By filling out the corresponding office names here, PTOS will include the proper office name on reports and lists. If you want different names and/or addresses to print on patient statements or insurance claims, call APS for assistance.

MONTHS FOR YEAR-TO-DATE REPORTS
Several MANAGEMENT REPORTS can be run showing totals for each month's activity during the year. Selecting this task lets you define the months you want to see on the reports.



DATE FORMAT
PTOS for windows allows you to select the date format you wish to use. When you select this option, the following screen appears:



Options 1 and 3 are self explanatory. With options 2 and 4, you enter a ONE DIGIT CENTURY and TWO DIGIT YEAR. March 14, 2004 would be entered "204/03/14" and March 14, 2005 would be entered "205/03/14". This allows you to save one keystroke per date. It may not seem like a big savings, but think of the number of times you need to enter the date.

You can start by selecting one date format and later try a different format. PTOS will make all necessary adjustments. **NOTE: ALL USERS MUST USE THE SAME FORMAT. ONE USER CAN NOT SELECT FORMAT 1, WHILE SOMEONE ELSE USES FORMAT 2. NOTE: This only affects data entry, it does not change how dates print on reports, lists or bills.**

GENERAL LEDGER POSTING DATA
If you are using the APS Accounting Module, PTOS can automatically transfer your daily charges, payments and adjustments into the General Ledger. If you instruct PTOS to update General Ledger, you are asked for the accounts debit and credit. You then enter the ACCOUNTS RECEIVABLE, Deferred Income, Fees Collected, and Cash in Bank accounts for posting. Whenever the Daily Transaction Report is printed, the totals for each day will be posted to the appropriate accounts.

SET SEARCH KEY PREFERENCE
Search Key Preference - When you want to search a list of codes or patient account numbers you can double click on the desired box or press the "F2" key. If you want to change to a different search key, such as F3 or F4, it can be changed here.

PRINTER LINE FORMATS
An extensive list of modifications are available for printing. You can modify where boxes print on insurance forms both vertically and horizontally. You can also modify label and superbill formats. On patient statements you can move the top of the statement and control how many lines of transactions print on each page to avoid wasted paper. NOTE: with HIPAA privacy standards the patient diagnosis should not be visible through a window envelope. By moving where the PAYOR data starts printing, you can control what is visible in a window envelope.

CLEAR TRAINING DATA
When you first learn PTOS you can enter dummy patients, transactions and other data. Then before using PTOS for real work, select this task to clear that dummy data. You can clear some codes while keeping others by checking which files to clear. Before clearing data, always back up your data first.

DISPLAY/CHANGE PATH TO DATA FILES
This is a selection that you shouldn't need to change once PTOS is initially installed. It tells your system where to look for PTOS data.

PRINT REPORTS IN BOLD
If your printer output appears too light, check this option to get darker print.

SHOW CALENDAR
When entering dates in PTOS a calendar can automatically pop up. It can be turned off here.

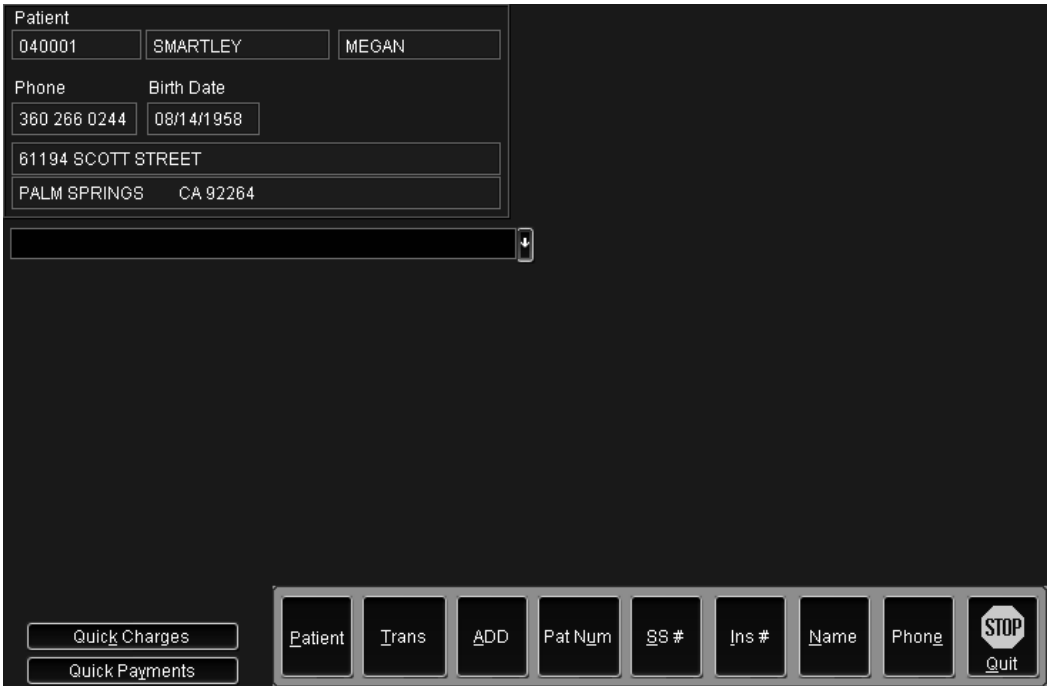
VALIDATE DATABASE DURING RESET
Validate Database During Reset – This should normally be left on and allows more extensive file checking when RESET FILES is run.

THE NEXT STEP

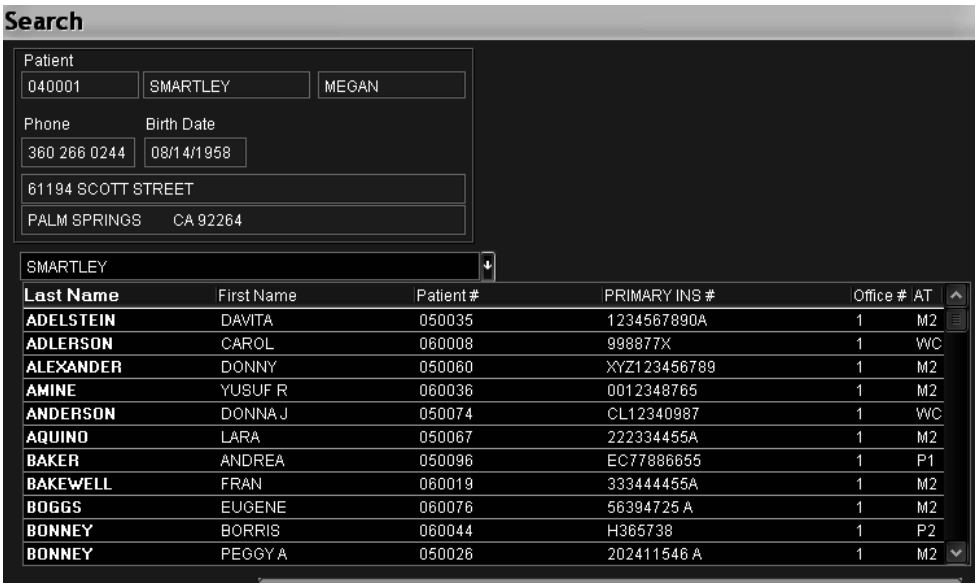
Once all codes are entered, you are ready to start putting your patients into the system. You'll want to enter all patients who are currently being treated and also discharged patients who still have an open balance. **"ENTER OR CHANGE PATIENT DATA"**, which we'll cover next. Posting the current balance for all patients is discussed in a later section. **"ENTER OR ADJUST TRANSACTIONS".**

2. PATIENT DATA

This task is used to add a new patient or to change or review information about an existing patient. When selected, the screen below will appear. The top left box shows information about the currently selected patient.



To find a patient by name, phone, patient number, social security number or primary insurance number id, type the search criteria in the text box and click the appropriate button. You don't need a complete name or phone number. In the example below, typing "RO" in the text box and clicking NAME causes BOB ROBERTS to be selected. You can click the PATIENT button OR double click the highlighted account OR type ALT + P to bring up the main patient data entry screen. If you click the TRANS button (or right click on the selected account or press ALT + T) the main transaction entry screen will come up.


Search
Patient
040001
SMARTLEY
MEGAN
Phone
Birth Date
360 266 0244
08/14/1958
61194 SCOTT STREET
PALM SPRINGS CA 92264
SMARTLEY
Last Name First Name Patient # PRIMARY INS # Office # AT
ADELSTEIN DAVITA 050035 1234567890A 1 M2
ADLERSON CAROL 060008 998877X 1 WC
ALEXANDER DONNY 050060 XYZ123456789 1 M2
AMINE YUSUF R 060036 0012348765 1 M2
ANDERSON DONNA J 050074 CL12340987 1 WC
AQUINO LARA 050067 222334455A 1 M2
BAKER ANDREA 050096 EC77886655 1 P1
BAKEWELL FRAN 060019 333444455A 1 M2
BOGGS EUGENE 060076 56394725 A 1 M2
BONNEY BORRIS 060044 H365738 1 P2
BONNEY PEGGY A 050026 202411546 A 1 M2

Assigning account numbers correctly is important. The PATIENT NUMBER can be alpha or numeric. The first digit MUST indicate the **"Revenue Center"**, or "**LOCATION**", as it is referred to in PTOS lists and reports. Most practices have one revenue center, and will use patient numbers that all begin with "1". You can, however, use several revenue centers, for a new office, or perhaps a work hardening center you wish to track separately.

If you already have a patient numbering system, you can probably continue with it, as long as you use the first digit as revenue center. To start a new numbering system, we suggest you use a six digit number, beginning with the revenue center digit. The first patient would be **"100001"**, then **"100002"**, etc. The 250th patient you enter would be **"100250"**.

***** NOTE *** All account numbers should be the same length. If you use a six digit number as recommended above, all account numbers must be six digits. Don't start with patient "1" then after nine patients start using "10" then later move to "100" as this will cause patient lists and reports to sort incorrectly.**

To add an account, click the ADD button. PTOS pulls up a screen asking for the new account number. If you want to see the last account number used, click the **FIND** button. If you are using several revenue centers, you can enter which location you wish to see the last number for. You can also specify which office if you have several offices. Type the account number you wish to assign. PTOS will verify the number has not already been used and bring up the patient data entry screen.

"Patient Data" is divided into five screens, the first containing patient data, the second containing referral information, the third insurance information, the fourth financial information and the fifth billing form customizing. All fields are explained on the following pages.

You do not need to fill in all information. If the patient is covered by only one insurance carrier, you would have nothing to enter for **"SECONDARY INSURANCE"**. Skip any unused fields, you can always come back and fill them in later. There are three fields that must be filled in, patient number, first and last name. All others are optional and are used in various reports and billings.

CODE FIELDS

There are several **"Code Fields"** in the patient file; Payor, Referring Dr., Primary Dr., ICD9, Primary and Secondary Insurance, Employer and Attorney. You've created a library of doctors, attorneys, diagnoses, etc., in the **"Update codes"** option of **"System Tasks"**. Now, instead of typing the names and addresses over and over, you type the code, and all appropriate data is automatically pulled in. Also remember that anywhere a city, state, and zip code are needed, you can enter a CITY code. Using CODES to pull in descriptions provides consistency in various LISTS and MANAGEMENT REPORTS.

FIELDS IN THE PATIENT DATA FILE
Below are the PATIENT DATA ENTRY SCREENS, along with brief descriptions of patient data fields, listed in the order they are filled out.

PATIENT DATA TOOL BAR

ARROW BAR: Allows you to move from patient to patient in alphabetical order or from first patient to last.

BILL PATIENT AND BILL INSURANCE NOW: Allows you to print a patient statement or insurance HCFA & UB92 form for the current patient.

SUSPEND/RECALL: In the bottom right corner of each PATIENT DATA ENTRY screen is a SUSPEND button. If you are interrupted during data entry and need to pull up another account, or go into transaction entry for another patient, click the SUSPEND button. This returns you to the SEARCH SCREEN. You can pull up another account, and at the bottom of their PATIENT DATA ENTRY and TRANSACTION screens will be a RECALL button. When you are finished with this account, press RECALL and it will close the current account and return you to where you were in the first patient's screen.

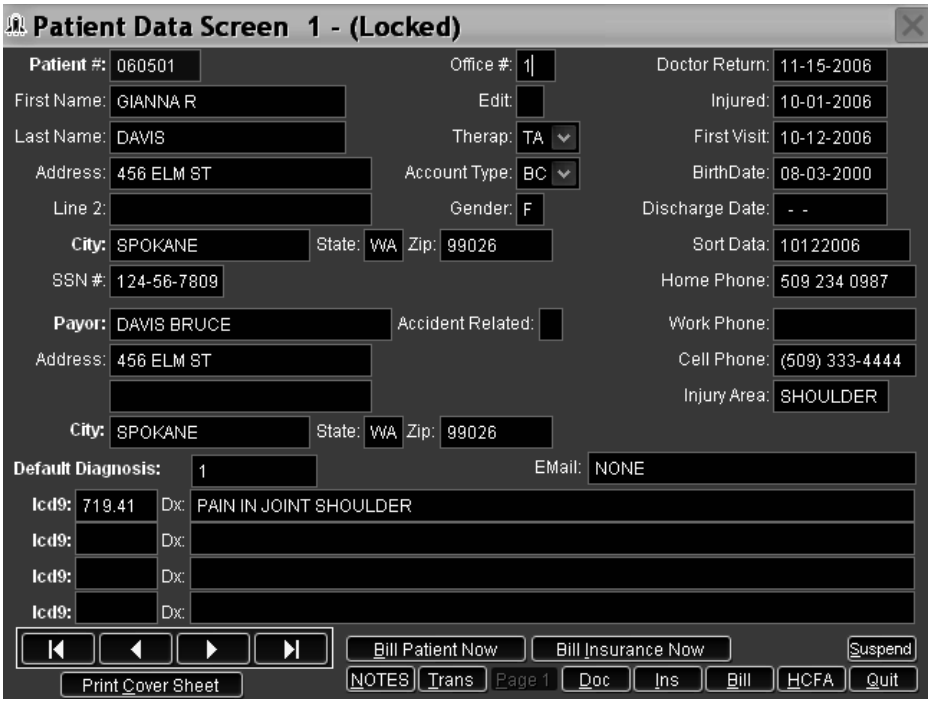
PRINT COVERSHEET: Allows you to print a condensed print out of the patient information.

NOTES: Takes you immediately to patient's note screen.

TRANS: Takes you immediately to patient's transaction screen to view patient transaction history or post charges, payments or adjustments

DOC, INS, BILL, HCFA: Allows you to quickly go from one patient data screen to another.

PATIENT DATA SCREEN 1



PATIENT # - All information about the patient including charges and payments is linked together by the patient number. Once you create a patient number, it can't be changed, except through the RENUMBER PATIENT ACCOUNTS option in SPECIAL TASKS.

FIRST NAME - Patient first name, also can add middle name or middle initial of the patient after the first name (i.e. Gianna R).

LAST NAME- Patient last name, also can add a suffix after the last name if required (i.e. Davis Jr)

ADDRESS - First line of patient's address.

LINE 2- Second line of patient address (if needed for additional information such as apartment or space number.

CITY, STATE, ZIP - of patient address

SS#: Patient's Social Security number

PAYOR - This is the party ultimately responsible for payment. Usually the patient, it could be a spouse or parent, in a legal case it could be an attorney. For Worker's Comp, you can enter the employer, insurance carrier or leave blank. If the patient is also the payor, simply type **"P"** in the PAYOR NAME field. PTOS will pull the patient's name and address down for you. If the payor has the same address, but different name, for example a spouse, type in the name, and type a **"P"** in the first address field. This will copy the address of the patient.

You can enter an INSURANCE company as PAYOR, enter the insurance code and the name and address are filled in. If you don't know the insurance code, DOUBLE CLICK or press F2 for a LIST.

ADDRESS -Payor address, line one.

LINE 2 - Second line of payor address.

CITY, STATE, ZIP - of payor address. **REMEMBER TO USE YOUR CITY CODES**

DEFAULT DIAGNOSIS- If you wish, PTOS will print the diagnosis line number (or numbers) in box 24E of the HCFA-1500. The appropriate diagnosis line # for each treatment is entered at the time a charge is posted. You can enter a default diagnosis line # here that will automatically be pulled in when a charge is posted. This could be the diagnosis line number such as a "1" or multiple #'s such as "1234" corresponding to the diagnosis code(s) found in box 21 on the HCFA-1500 form. This field will automatically default to "1".

ICD9- A standard set of ICD9 codes and descriptions is included with the system. These can be modified or added to by you, under **"Update Codes"** in System Tasks. By entering the code here, the appropriate description will be copied to the DX (description) field. The primary ICD9 diagnosis code should be entered first, with additional codes, if necessary, in the following ICD9 fields. These can all be pulled in with the F2 key.

DX - As described above, this is usually filled in automatically by entering a code in the previous field, but you can enter a unique description if you wish.

OFFICE #- If yours is a multi-office practice, you are able to enter an office number in the patient account, showing where the patient is being treated.

EDIT- After a period of time, you may want to completely remove a patient from the system. Entering "A" in the EDIT filed will enable all patient and transaction data relating to the account to be removed when the **"REMOVE OLD ACCOUNTS"** task is run. A patient can only be removed if the balance due is zero. If a balance is outstanding, and you wish to archive the account, an adjustment must first be entered in the transaction file to **"zero out"** the account.

PTOS also uses the EDIT field for several internal functions. You may periodically see an **"N"** or and **"*"** in the EDIT field. These are just marks PTOS is using for tracking.

THERAPIST - Each therapist was assigned a code in the UPDATE THERAPIST CODES task. The primary therapist for the patient is then entered here. PTOS will use the code of the assigned therapist to fill out boxes on the HCFA-1500 billing form. This code will also be used when entering transactions to indicate which therapist treated the patient.

The THERAPIST and ACCOUNT TYPE boxes both have DROP DOWN LIST options. Clicking the arrow on the right of the field will display all valid codes. You can right click the appropriate code, or type it in.

ACCOUNT TYPE- Account type consists of two characters. The first is the basic classification, if the patient is a Medicare account, **"M"** must be entered as account type. All other categories can be assigned by you. Some suggestions are; W = worker's comp, D = dual private insurance, S = single private insurance, L = lien, C = cash.

A second digit for account type is optional, and indicates a sub-group for example, **"MP"** could be Medicare with additional private insurance, **"MM"** could be Medicare with Medicaid. This gives you detailed activity breakdown in various reports, and greater billing control.

When you enter an account type code, PTOS checks to see if it's in the account type file. If it is, all corresponding patient's data fields are filled out appropriately.

When you post transactions, the patient's account type is tracked. If you later change the account type in the patient file, you may want to change the account type in all transactions posted for the patient as well. This can be done in the RENUMBER ACCOUNTS task under SPECIAL TASKS.

PATIENT SEX- M for male or F for female.

DR RETURN- Before a patient returns to the referring physician, you may need to prepare a progress report. Entering the scheduled date of return to physician will enable a list to be printed which aids the therapist in scheduling reports and treatment progress. If the patient has additional treatments a new return date may be entered. Also can be used in tracking when a patient needs a new RX or plan of care.

DATE INJURED- Date of injury or onset of illness, this field will print in box 14 of the HCFA form and or box 32 of the UB92 form.

FIRST VISIT- First date patient was treated. This is how VPTOS tracks new patients in your system.

BIRTHDATE- Patient's date of birth.

DISCRG DATE- When a patient is discharged, enter the date. To track dropout patients, enter the year and month the patient dropped out, followed by **"00"** (e.g. 2004/07/00).
*****NOTE*** Some reports need to calculate data about discharge patients. And other lists can be printed only for active patients. For these to be accurate, AND TO REMOVE OLD ACCOUNTS, you must fill out the DISCHARGE DATE field when the patient is discharged.**

SORT DATA- This can contain any unique information you wish to track for the patient population. Under **"PATIENT LISTS"**, a list of all patients can be run, sorted by the entry in this field. This would then group all patients by whatever you wish to track for an additional demographic report.

HOME PHONE- Patient home phone.

WORK PHONE- Patient work phone.

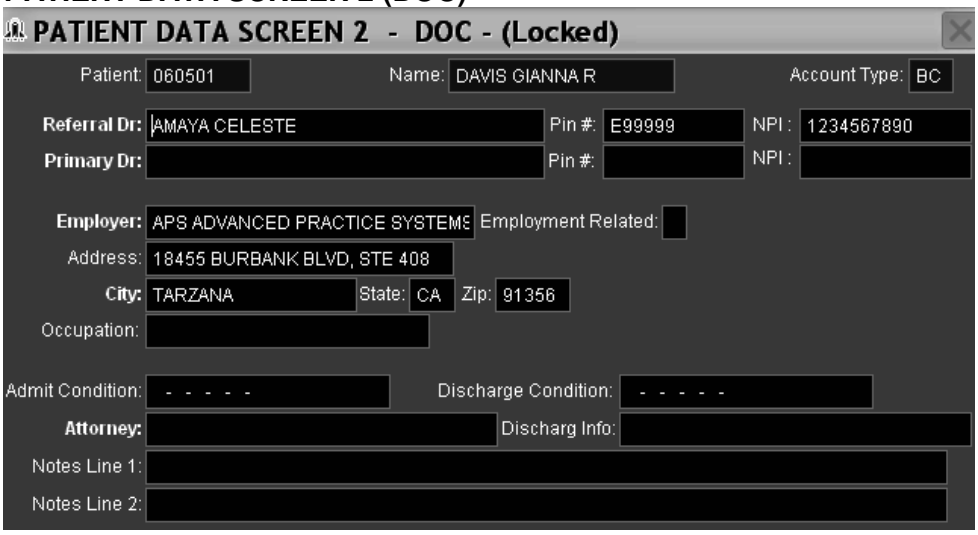
CELL PHONE - Enter the patient's cell or other phone number

EMAIL - You can enter an email address for contact

INJURY AREA- This is used for general description of injury area, such as BACK, KNEE, or FOOT. It allows a series of general injury type lists and reports, rather than the groupings by specific diagnosis code. If INJURY AREA is filled out in the ICD9 CODE file, the INJURY AREA is automatically filled out when a primary diagnosis is entered.

ACCIDENT RELATED- Indicates if the patient is being seen for an accident related condition; A= auto accident, O= other accident, or leave blank. This field will answer boxes 10B & 10C.

PATIENT DATA SCREEN 2 (DOC)



REFERRAL DR, PIN# AND NPI#- Referring physician, PIN # and NPI # if required, can be entered here. This will be printed on various insurance forms where referring doctor is requested, and is also used to group patients on the REFERRAL REPORTS and various patient lists. For grouping on lists and reports to be accurate, the referring doctor must be entered the same each time. AMAYA CELESTE AND CELESTE AMAYA, are two different people as far as PTOS is concerned. To make entering the referral the same each time, we recommend that you pull in the name with a referral code. To find the proper referral code, DOUBLE CLICK or press F2.

PRIMARY DR, PIN# AND NPI#- In many cases, the primary care physician also needs to be tracked, and may need to be used on the insurance form instead of the referring doctor. PTOS looks at the patient's account type to see if the primary or referring doctor should print on claims.

EMPLOYER NAME- The patient's employer can be entered here. It will print on the Patient Statement and various lists and reports. If, as in a Worker's Comp case, the EMPLOYER is the same as the PAYOR, just type **"PA"** in this field, and PAYOR name and address will be copied. You can also double click or press F2 for a list.

ADDRESS- Employer address line 1.

CITY, STATE, ZIP- Of employer address.

ADMIT COND- Upon admission, the patient can be evaluated in up to six categories such as functional level, pain, strength, or others you designate. These numerical values are on a scale of 0 to 10 and entered in each of the 6 ADMIT CONDITION categories. You can use a percentage, such as 70 or 45 percent instead of a "level" if you wish. Before establishing the criteria you use in the ADMIT COND and DISCRG COND fields, you should read the OUTCOME REPORT options in the MANAGEMENT REPORTS section.

DISC COND- On discharge, the patient is evaluated on the same six categories as ADMIT COND. Several OUTCOME REPORTS can then be run in MANAGEMENT REPORTS.

*****NOTE*** IT IS CRITICAL THAT CATEGORIES BE CONSISTENT. IF STRENGTH IS THE FIRST CATEGORY, ALWAYS ENTER THE VALUE FOR STRENGTH IN THE FIRST POSITION. IF SOMETIMES YOU ENTER THE STRENGTH VALUE FIRST AND SOMETIMES YOU ENTER FUNCTIONAL LEVEL FIRST, THE OUTCOME REPORT WILL BE MEANINGLESS.**

ATTORNEY- This can be used to track referring attorneys. If the attorney is entered in **"Update Referral Codes"**, enter the code in this field, or use F2 to select the appropriate name.

NOTES LINE 1 and 2 are displayed on this screen. To access additional notes, click the NOTES button at the bottom of each PATIENT DATA ENTRY screen. NOTES LINE 1 and 2 are the most significant, and we suggest using them for tracking specific information. For example, you could dedicate NOTES 1 for insurance authorization information, so it's always easily accessible.

NOTES LINE 1- Notes can be entered and tracked for each patient. Any notes relating to the account can be entered, for example, collection notes or missing items from the patient chart. A list can be printed from the **"PATIENT LISTS"** menu of any patients with entries in these fields.

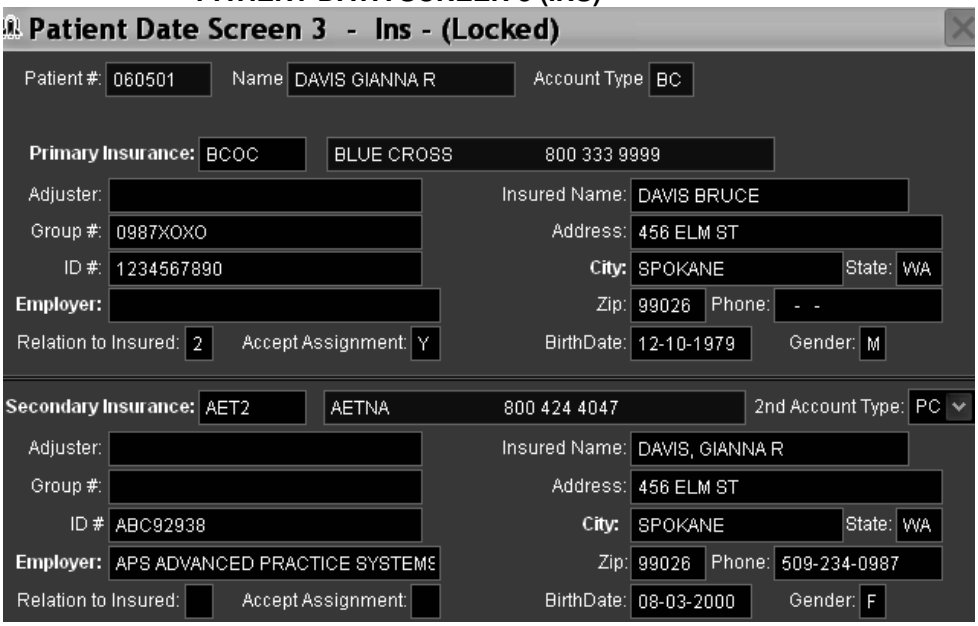
NOTES LINE 2- We recommend this line to enter the most current collection information. When you run DELINQUENCY REPORT, PTOS asks if you want NOTES LINE 2 on the report, for each of the delinquent accounts, allowing the most current collections notes to be printed.

EMPLOYMENT RELATED- Indicates if the patient is being seen for an employment related condition; Y)es or N)o. This field will print in box 10A on the HCFA form.

OCCUP- Patient's occupation.

DISC INFO- A description of the patient's condition on discharge can be entered, and is printed on various reports.

PATIENT DATA SCREEN 3 (INS)



PRIMARY INSURANCE- Insurance carrier information is entered in **"Update Insurance Carriers"** under System Tasks. Entering the code in this field will cause the appropriate insurance name and phone number to be displayed, and to be printed on insurance claims. DOUBLE CLICK or use the F2 key to quickly find the right code. **If you want the insurance claim addressed to the PAYOR, enter "PA" as the PRIMARY INSURANACE CODE.**

*****NOTE*** YOU MUST HAVE A CODE ENTERED IN THE PRIMARY AND/OR SECODNARY INSURANCE FIELD IF YOU WANT AN INSURANCE FORM TO BE PRODUCED. Otherwise PTOS assumes they have no insurance coverage and they can only be billed on the patient statement.**

ADJUSTER- A specific claims adjuster for the account can be entered and will print as part of the address on the insurance form. Some HCFA-1500 forms have **"BAR CODES"** in the top left corner. There is no room for the ADJUSTER to print on these forms.

GROUP#- Group number of the primary insurance subscriber, prints in Box 11 on HCFA form and box 62 on UB92 form.

ID#- Insurance ID number of the primary insurance subscriber. This is frequently the Social Security Number. If you've entered the Social Security Number on the second PATIENT screen, just type **"SSN"** in this field and the number will be copied automatically. Prints in Box 1A on HCFA for and box 60 on the UB92 form.

EMPLOYER- The employer for the primary insured is entered here and will print on the HCFA form. If "P" is entered for INSURED NAME (see below), the patient's employer (as well as birthdates, sex, and relationship code of "1") will automatically be pulled in.

PATIENT RELATION TO INSURED- Relationship of patient insured party for the primary insurance; 1= self, 2= spouse, 3= child, 4= other. For Box 59 of the UB92 form you can enter the codes shown on the following page and the corresponding UB92 code will print.

CODE	PRINTS	CODE	PRINTS	CODE	PRINTS	CODE	PRINTS
1-9	01-09	E	19	J	24	O	41
A	10	F	20	K	29	P	43
B	15	G	21	L	32	Q	53
C	17	H	22	M	33	R	G8
D	18	I	23	N	36		

INSURED NAME- name of subscriber for primary insurance. This could be the patient, the payor or another party, such as employer. If the patient is the subscriber, type **"P"** in this box and subscriber name and address data will be copied. If the subscriber is different from the patient but the same as the payor enter **"PA"** and payor name and address information will be copied. If the employer is the insured party, type **"EMP"** and the employer name and address are pulled in.

ADDRESS- Line one of subscriber address.

CITY, STATE, ZIP- Of primary insured's address.

ACCEPT ASSIGNMENT- this can be Y (yes), N (no) or blank, and determines how the assignment box of the HCFA-1500 is checked.

BIRTHDATE- Primary insured's birth date.

SEX- primary insured's sex.

SECOND INSURANCE- Enter any secondary insurance code here.

2ND INS TYPE – The account type for secondary insurance is entered here. This will control formatting of the HCFA-1500 form including appropriate therapist provider numbers.

ADJUSTER- Adjuster for secondary insurance.

GROUP # - group number for secondary insurance subscriber.

ID#- Identification number for the subscriber to the secondary insurance. You may enter **"SSN"** to pull the patient's social security number in.

EMPLOYER- Employer for the secondary insured party is entered here. If "P" is entered, the patient's employer, birth date, sex, and relationship code of "1" will automatically be pulled in.

PATIENT RELATION TO INSURED -Relationship of patient to insured party for the primary insurance; 1 = self, 2 = spouse, 3 = child, 4 = other.

INSURED NAME- Name of insured subscriber for secondary insurance. As with the PRIMARY INSURED NAME, you can enter a "P", "PA", or "EMP".

ADDRESS -Line one of subscriber address.

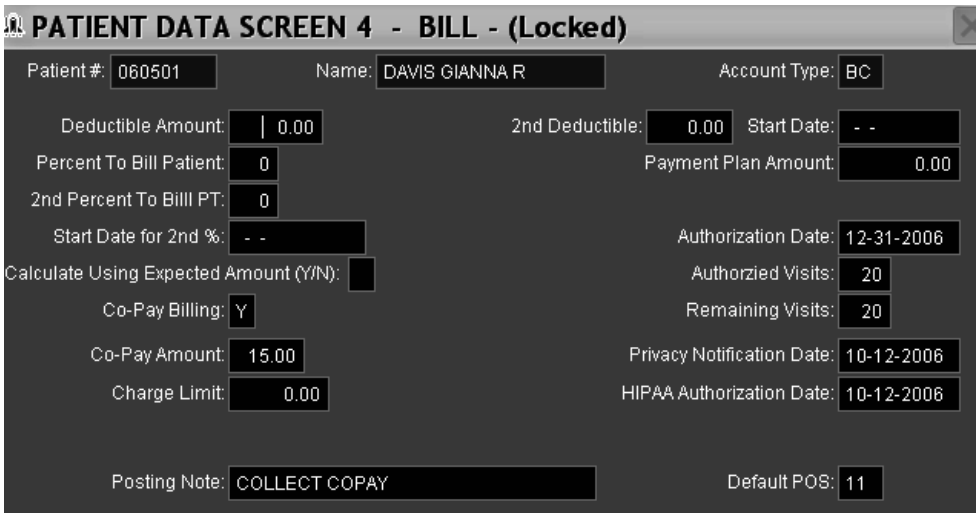
CITY, STATE, ZIP -of secondary insured's address.

ACCEPT ASSIGNMENT- This can be Y (yes), N (no) or blank.

BIRTHDATE -Secondary insurer's birth date.

SEX -Secondary insurer's sex.

PATIENT DATA SCREEN 4 (BILL)


PATIENT DATA SCREEN 4 - BILL - (Locked)
Patient #: 060501
Name: DAVIS GIANNA R
Account Type: BC
Deductible Amount: 0.00
2nd Deductible: 0.00
Start Date: - -
Percent To Bill Patient: 0
Payment Plan Amount: 0.00
2nd Percent To Billl PT: 0
Start Date for 2nd %: - -
Authorization Date: 12-31-2006
Calculate Using Expected Amount (Y/N):
Authorzied Visits: 20
Co-Pay Billing: Y
Remaining Visits: 20
Co-Pay Amount: 15.00
Privacy Notification Date: 10-12-2006
Charge Limit: 0.00
HIPAA Authorization Date: 10-12-2006
Posting Note: COLLECT COPAY
Default POS: 11

DEDUCTIBLE AMOUNT- Many insurance plans include a deductible the patient must satisfy before the insurance pays benefits. The insurance may then pay a percentage of charges over that amount. Usually the patient has seen a physician and has already satisfied at least a part of that deductible. If you know what remains of the original deductible, enter it. If you aren't sure,

you don't need to fill it in. When PTOS bills the patient, it will bill the patient for all charges up to the deductible. After the deductible is reached, the system will bill the PERCENT TO BILL PATIENT (below). If the patient originally had a deductible of $250, and they've already paid $100 to other providers, enter $150 as their deductible. You can choose to have the deductible calculate based on the actually charge amount or the expected amount. (See **CALCULATE % OF EXPECTED AMOUNT** below).

PCT TO BILL PATIENT- this is the percentage of charges (in addition to the deductible), that the patient will be billed. If the insurance carrier pays 80%. Enter **"20"** in this field, and the patient will be billed for 20 percent of the charges. Usually the patient is responsible for any amount not paid by their insurance. After the insurance has paid their portion of the bill, PERCENT TO BILL PATIENT can be changed to **"100" a**nd the patient will be billed the balance due.

2ND PCT TO BILL PT- Sometimes the percent to bill the patient may change during the course of treatment. Perhaps a "Co-pay" applies up to a certain amount, or a new patient percent is activated after a charge limit is reached. Fill in the new percent to bill here and the starting date for the new percentage in the START DATE FOR 2ND % field.

CALCULATE % OF EXPECTED AMOUNT (Y/N)- When a percent to bill the patient is calculated, normally the amount billed is used. If the patient is billed $100 and they are responsible for 20%, they will be billed $20. For some accounts, Medicare for example, you may wish to bill the patient their percent of the EXPECTED AMOUNT (Expected amounts were covered in UPDATE PROCEDURE CODES). This option will calculate from the patient deductible and expected amounts.

If you bill Medicare $100, and the EXPECTED AMOUNT has been entered as $80, you have the option of billing the patient 20% of $80 rather than 20% of the $100. To base the patient percent on the expected amount, enter YES in this field. If this is set to YES, the expected amount is also used when calculating the CHARGE LIMIT for the patient.

CO-PAY BILLING (Y/N)- Many insurance plans designate a co-pay amount which is the portion of the charge that the patient must pay. If you enter **"Y"** for yes in this box, PTOS will know to calculate the co-pay amount as the patient's responsibility. PTOS will then bill the patient for all charges up to the DEDUCTIBLE AMOUNT entered above, and then bill only the co-pay amount after the deductible is reached.

CO-PAY AMOUNT - When you set up ACCOUNT TYPE codes, you entered a CO-PAY amount for applicable account types. By filling in ACCOUNT TYPE on Screen 1, this field is filled out. You can also enter your own amount here. If CO-PAY is set to yes, but no amount is entered here, PTOS will use the CO-PAY in the PROCEDURE CODE when a charge is posted.

IMPORTANT!! If CO-PAY is not set to YES, and transactions are posted, those charges will not be billed the CO-PAY amount. CO-PAY must be set to YES in this field at the time the charge is posted. If necessary, you can go back and MODIFY charges that should have a co-pay and enter the appropriate amount. This is described in the next section. Also, co--pay will override the PERCENT TO BILL PATIENT and 2ND PCT TO BILL PT above. If you want the "second percent to bill patient" to take effect, you must change CO-PAY to "NO" at the time that START DATE FOR 2ND % is to take effect.

CHARGE LIMIT- If the patient can only be treated up to a maximum amount of charges or Insurance CAP (i.e. Medicare $1740.00 CAP), either determined by the insurance carrier or your credit policy, enter that amount here. PTOS will flag you if the charge limit has been reached as charges are being posted. If "CALC % OF EXPECTED AMT" has been set to yes, the expected amount is used when calculating the CHARGE LIMIT maximum for the patient.

POSTING NOTE- You can enter a short reminder note here that will appear on the screen when you are posting transactions. This note is frequently the same for all patients in the same account type. It can therefore be pulled in from the account type file.

2ND DEDUCTIBLE- At the beginning of a new time period, there may be a new deductible to satisfy. Enter the new deductible here and date it takes effect in the START DATE field. PTOS will then calculate this deductible.

PAYMENT PLAN AMOUNT- When you send a patient statement, PTOS will bill the patient for the entire portion of the balance for which they are responsible. You may make PAYMENT PLAN arrangements with certain patients, however, to pay a specific dollar amount weekly or monthly. If you enter an amount in this field, such as $25.00 or $50.00, this is the amount the patient will be billed whenever a patient statement is sent.

AUTHORIZATION DATE- Calling every insurance carrier for treatment authorization can make a BIG impact on collections and accounts receivable. When called, the carrier will frequently authorize treatment up to a specific date, or for a fixed number of visits. Enter the date that authorization expires. You can then generate lists of patients whose insurance authorization is about to end, so carriers can be called for reauthorization.

AUTHORIZED VISITS- If the patient's insurance authorizes a set number of visits, that number should be entered here. If they later authorize more visits, ADD that number in. You can then track the total number of visits that were authorized.

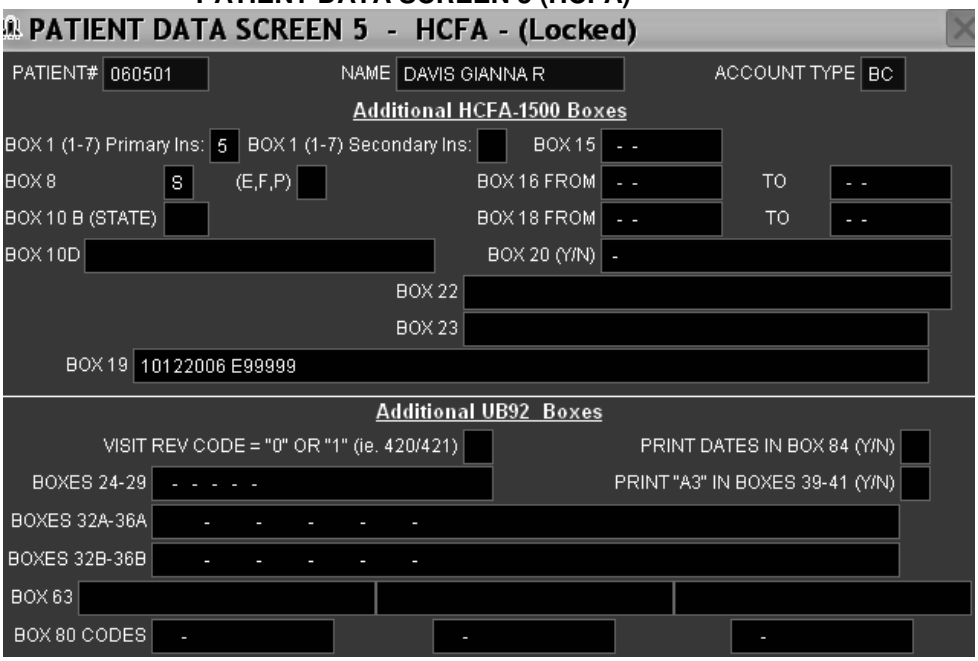
REMAINING VISITS- If the insurance authorizes, or you want to assign a specific number of treatments, that number can be entered here. PTOS will then track how many visits remain as the patient is treated. The number can be reset if more visits are authorized. This is different from AUTHORIZED VISITS in that it shows how many visits REMAIN on the plan of treatment, while AUTHORIZED VISITS shows the total that were authorized.

PRIVACY NOTIFICATION DATE – The date you give the patient a copy of your privacy policies should be entered here for HIPAA compliance tracking.

HIPAA AUTHORIZATION DATE – If the patient authorizes use of their private health information (PHI), the expiration date of that authorization should be entered here.

DEFAULT POS- PLACE OF SERVICE codes are assigned by insurance carriers. If you wish to print POS in box 24B of the HCFA-1500, enter a default POS here. It will be pulled into transaction entry and can be changed if the patient was treated at a different facility.

PATIENT DATA SCREEN 5 (HCFA)



PTOS fills out the HCFA-1500 and UB92 billing forms in a standard format specified by Medicare and common insurance carriers nationally. This screen contains boxes that you can use to customize billing to your needs.

BOX 1- Enter 1 through 7 to indicate which of the seven boxes at the top of the HCFA form should be checked, such as 1 for Medicare and 7 for other, for primary and secondary insurance.

BOX 8 - Patient status: S = single M = married 0 = other
E = employed F = full-time student P = part-time

BOX 10B – If an auto accident, enter the state.

BOX 10D – Any text to print in 10D is entered here.

BOX 15 – Date of same illness can be entered if needed.

BOX 16 – If UNABLE TO WORK DATES are entered, they will be filled out on the HCFA-1500 and used in Outcome Reports and some patient lists.

BOX 18- Hospitalization dates can be filled out if needed.

BOX 19 -Any data required by individual insurance carriers can be entered here. Many carriers ask for the referring doctor's PIN#. Enter "UPIN" and PTOS will pull in the PIN# from the **DOC** screen. Entering the date last seen by the doctor is also commonly done. You can type "LAST DATE SEEN BY DR.:", enter the date, then update it as needed.

BOX 20- Outside lab information can be entered.

BOX 22- Can be filled out if required, with Medicare resubmission codes.

BOX 23- A PRIOR AUTHORIZATION number may be required and should be entered here

ADDITIONAL UB92 BOXES If your office is a Certified Rehabilitation Agency and you billing on the UB92 form, you can use these fields to override the PTOS defaults.

VISIT REV CODE = "0" OR "1" (i.e. 420/421)- Some intermediaries require treatment codes to end with **"0",** others require a **"1",** For example, 420 or 421 are used as physical therapy treatment codes. This parameter allows you to control the codes printing on the UB92.

BOXES 24-29 – Enter any codes here to print in these boxes.

BOXES 32-36 (Lines A and B) -Normally, PTOS prints "11", "35", '44" and/or "45" with the appropriate dates in boxes 32 to 36 of the UB92. If you are required to print the code 29 or 17, you can add in the first slot the required occurrence code followed by the appropriate eight digit date in the format shown below for October 1, 2006.

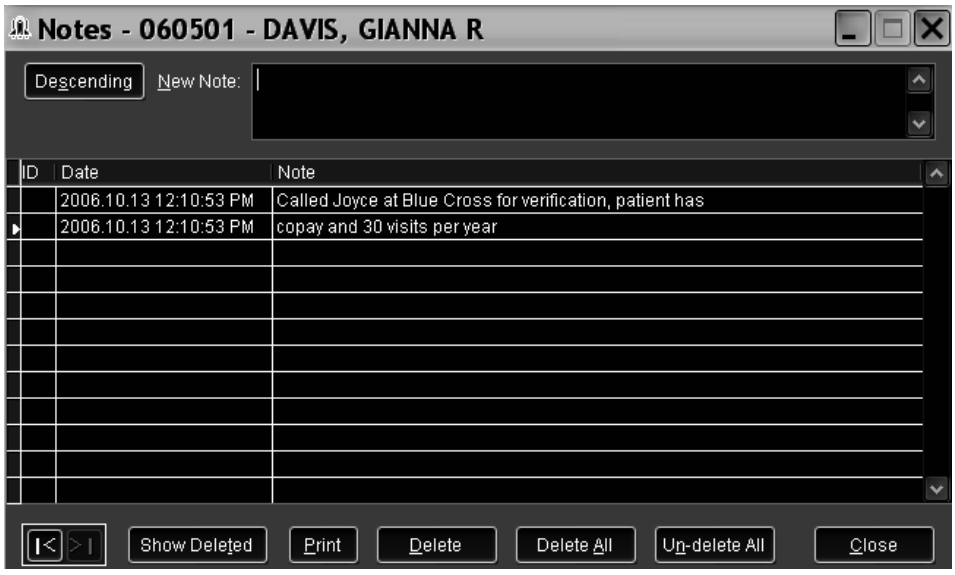
BOX 63 CODES- You can enter three TREATMENT AUTHORIZATION CODES as needed.

BOX 80 & 81 CODES- You can enter up to three dates and procedure codes here, Corresponding to the format of boxes 80 and 81.

PRINT DATES IN BOX 84 (Y/N)- Each date of service covered on the UB92 can be printed in BOX 84 by selecting Y)es.

PRINT "A3" ON THE UB92- This value code prints in box 39, 40 or 41 of the UB92 and is required by some but not all intermediaries. Enter Y)es to print A3.

PATIENT NOTES SCREEN



ASCENDING/DESCENDING: Displays notes in date order.

NEW NOTE: Type any notes pertaining to your patient account such as insurance benefits and or telephone calls made or received by the insurance carrier, patient, or attorney regarding your patient's account. You must press the "enter" key so that your note will be saved.

SHOW DELETED: Will display deleted notes.

PRINT: Allows you to print patient notes to paper.

DELETE: Click on (highlight) the note you wish to delete and press the delete button

DELETE ALL: Allows for all notes to be deleted

UN-DELETE ALL: This option will bring back into notes screen all deleted notes

CLOSE: Ends the note session

ADDITIONAL PATIENT SCREEN INFORMATION:

LOCKED/UNLOCKED
ALL PATIENT SCREENS show LOCKED or UNLOCKED at the top of the screen. If you are running on a network and pull up an account, it is UNLOCKED. If you start making modifications to the patient's data, PTOS automatically locks the patient record. Other users can view the patient account but they cannot modify it until you close the record thereby unlocking it.

DELETING AN ACCOUNT
If you want to remove a patient account from the system, first delete any transactions you've entered for the patient, then PRINT NEW AND DELETED TRANSACTIONS from the DAILY TASKS option. Finally, erase the patient's first and last name from the Patient Data Screen. PTOS will then consider this an invalid account and remove it when RESET FILES is run.

RENUMBERING AN ACCCOUNT
If you wish to change a patient account number, select RENUMBER PATIENT ACCOUNT from the SPECIAL TASKS menu. This could be necessary if the revenue center to which the patient is assigned has changed. The patient's account number, and all transactions related to the patient, will be renumbered.

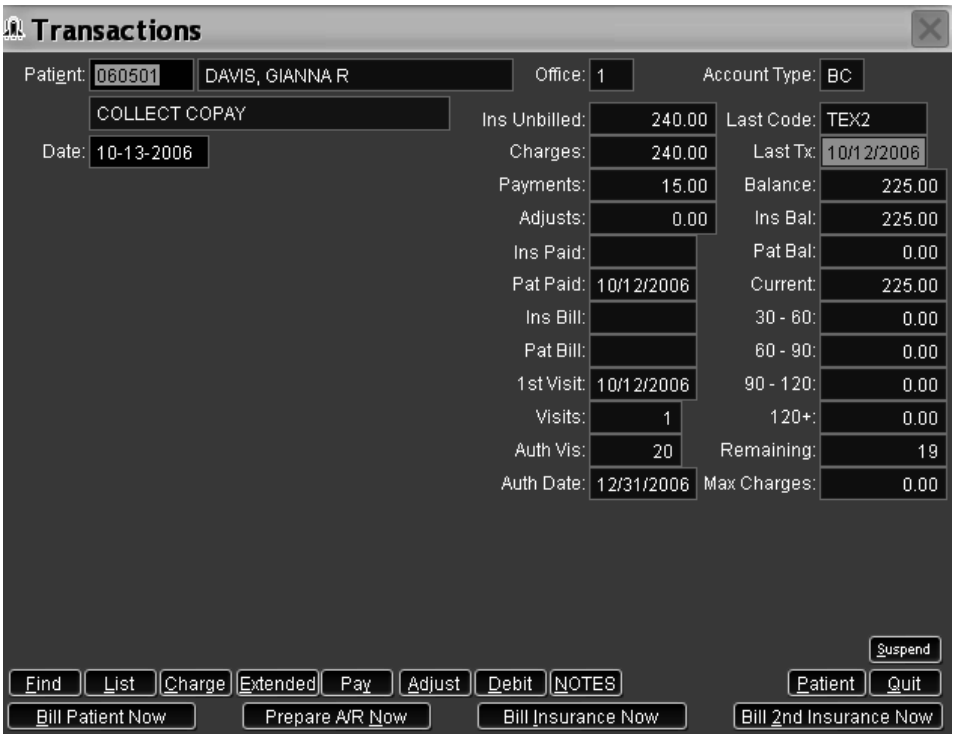
Once patients have been entered, you can start posting charges and payments so that PTOS can do your billing and create statistical reports. The first transaction for your existing patients when you convert to PTOS, will be entering their current balance. Entering beginning balances and all transaction posting is explained in the following section.

3. TRANSACTIONS

Transactions are entries that affect the balance of an account. They include charges, payments and adjustments. Before transactions can be posted, the patient account must exist in PTOS.

Selecting "TRANSACTIONS" from the MENU BAR pulls up the same SEARCH screen as ENTER PATIENT DATA described previously. You can use the same techniques to find the patient. RIGHT CLICKING on the proper patient or clicking the **TRANS** button pulls up the main TRANSACTION screen shown on the next page.

The data displayed gives an up-to-the-minute picture of the account. It allows you to quickly spot an account with a high balance, someone who has only a few visits remaining on their treatment plan, or an account that has somehow not been billed on schedule. You can also click the **PREPARE A/R NOW** button to age the account up to the minute.



Making sure that the patient doesn't exceed authorized treatment is important. PTOS therefore checks the patient's AUTHORIZED VISITS and AUTHORIZATION DATE. If the authorization date, authorized visits or maximum charges have been exceeded, the screen will highlight these fields in yellow. The POSTING NOTE also appears in yellow below the patient's name.

FINANCIAL DATA FIELDS

ACCOUNT TYPE- The patient account type, as explained under ENTER PATIENT DATA.

INS UNBILLED- Charges which have not yet been billed TO AN INSURANCE CARRIER are shown here. When an insurance claim is sent, the amount billed is subtracted from UNBILLED CHARGES. If the patient has no entry in the PRIMARY INSURANCE or SECONDARY INSURANCE fields of the Patient Data Screen, such as a cash account, PTOS knows there is no insurance to track unbilled charges for. In this case, UNBILLED CHARGES will be reset to zero whenever AGED ACCOUNTS RECEIVABLE is prepared.

CHARGES- Total charges to date.

PAYMENTS- All payments received from insurance carriers and the patient.

ADJUSTS- Total adjustments on the account. Including items like credits for courtesy discounts or insurance write-offs. Adjustments are explained in detail later in this section. This could be positive, if there are debit adjustments, or negative, if there are credit adjustments.

INS PAID- When a payment from the insurance carrier is posted, the date is entered here. You can easily see an account with a high BALANCE and no insurance payments.

PAT PAID- The last date a patient payment was received.

INS BILL- When an insurance claim is printed, the billing date is updated. You can find when the insurance carrier was last billed.

PAT BILL- The last date a patient statement was printed.

1ST VISIT- This is the first day of treatment and lets you know exactly how long the patient has been coming.

VISITS -Total visits to date

AUTH VISITS- The authorized number of visits, as you entered them in the patient account.

AUTH DATE- The date treatment authorization expires, as you entered.

LAST CD -The last PROCEDURE CODE that was posted.

LAST TX -This is the last date the patient was treated.

BALANCE -Probably the single most important piece of financial information. This amount is updated immediately whenever you enter a charge, payment or adjustment. You can always find exactly what is owed.

INS BAL -Since you've entered the DEDUCTIBLE and PERCENT TO BILL PATIENT, or CO-PAY billing, in the Patient File, PTOS can calculate the patient and insurance portion of the balance. This field shows the insurance portion of the total balance.

PAT BAL -This is the patient's portion of the total balance**. ***NOTE*** If you answered yes to "CALC % OF EXPECTED AMT" in the Patient File this amount will reflect the percent to bill patient multiplied against the EXPECTED AMOUNT of each charge**.

CURRENT, 30-60, 60-90, 90-120, 120+- These five fields show aging of patient balances, and again, allow you to quickly spot slow paying accounts.

REMAINING -This shows how many visits remain on the treatment plan.

MAX CHARGES -Maximum charges you designated in the patient account.

There are several tasks you can perform from the main transaction screen. When you first pull up the screen, the **PATIENT ACCOUNT NUMBER** box is active. If you wish to pull up a different account, you don't need to end and go back to the **SEARCH** screen, but can just enter the correct account number here. You can also use F2 or double click to find the right patient. We'll cover the various options available from this screen, starting with posting charges.

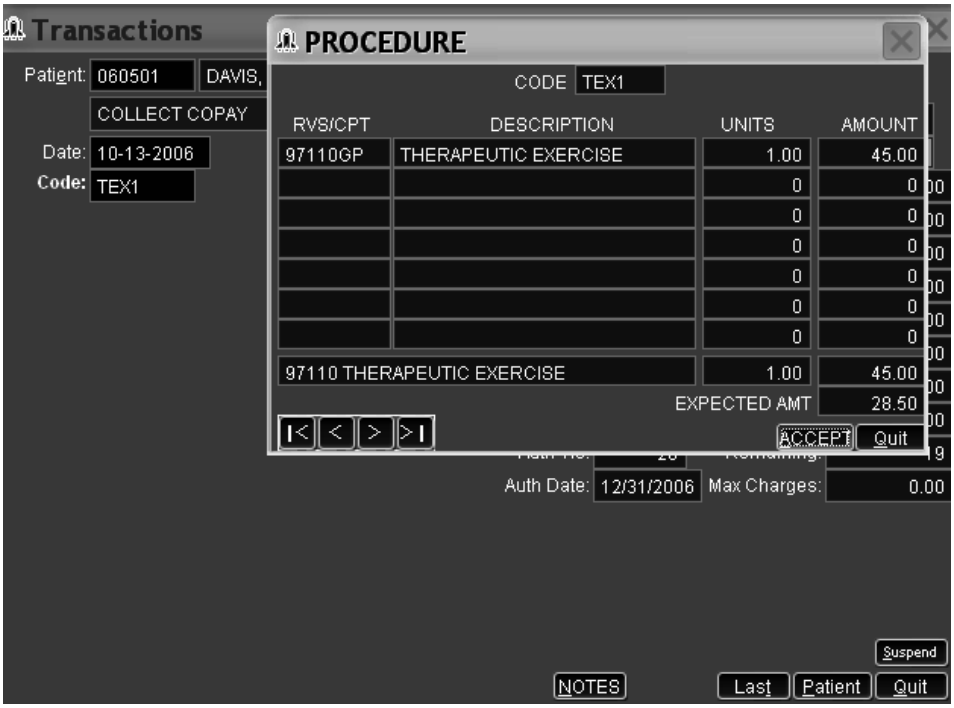
Once you have selected the correct patient account, PTOS asks for the transaction date you wish to work with. The date defaults to the SYSTEM DATE, but you can enter any date needed. Next indicate if you want to add, find or list transactions. If you have entered a CLOSING DATE in the ACCOUNTS RECEIVABLE section of CHANGE PARAMETERS in the SYSTEM TASKS menu, no transactions prior to the closing date can be entered, deleted or modified.

ADDING CHARGES
If you wish to add a charge single charge, click **CHARGE**. PTOS will then ask for a TRANS CODE. You may enter on the PROCEDURE CODES you've created or enter **"I"** to enter an INDIVIDUAL charge.

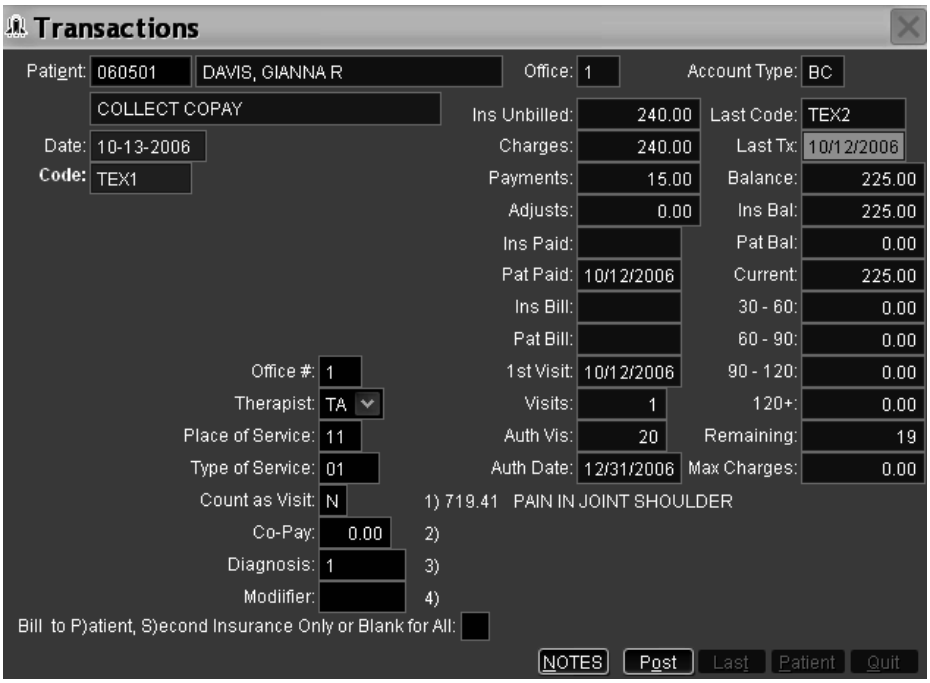
PROCEDURE CODE
This is usually the most efficient way to enter information. Just type the appropriate PROCEDURE CODE. If you aren't sure what the code should be, look to the top of the ENTER OR ADJUST TRANSACTIONS screen, where the LAST CODE used is displayed.

If this isn't the right code for today's visit, you can press the F2 key or double-click to display any codes that might apply. If the treatment consists of Ther Ex, type THER EX as the name to search, and press <enter>. Any PROCEDURE CODE which contains **"THER EX"** anywhere in the STATEMENT DESCRIPTION is listed.

After selecting the code, all procedure data is displayed for verification, including descriptions, codes and fees. This is shown on the screen below. If this is the right code, click ACCEPT, or you can use the VCR buttons to find another procedure, or click QUIT to return to the main TRANSACTION screen.



When the charge is accepted, additional information about the visit is pulled up as shown below, and can be modified as needed.



OFFICE #- This is the assigned office for the patient as entered in the Patient File. If the patient was treated at a different office, it can be designated here.

THERAPIST -The treating therapist is automatically filled in from the assigned therapist, which can be changed if someone else treated the patient. This is used on the THERAPIST ACTIVITY REPORT, and various lists to calculate charges generated by each therapist.

PLACE OF SERVICE - is only used on insurance forms. The default for this field is pulled from the Patient Data Entry Screen.

TYPE OF SERVICE (TOS) - is also used only on insurance forms. Most insurances don't require POS or TOS, so you can probably skip them. If you've filled out TOS in the PROCEDURE CODE, it is automatically pulled in here. If you've entered a DEFAULT POS on the fourth patient screen, this is automatically pulled in. Both TOS and POS can be changed if needed.

COUNT AS VISIT -YES or NO, is used to calculate the number of patient visits on management reports. The default is count as visit YES, but if posting a supply item, or possibly posting several procedure codes to cover the same visit, you could change it to NO. If the PROCEDURE CODE begins with a **"Z" "ZCANE",** PTOS will automatically set COUNT AS VISIT to **"N"**.

BILL PATIENT ONLY -defaults to blank (NO) unless it has been set to YES for the specific PROCEDURE CODE. If you specify YES, to only bill this transaction to the patient, then it will not be included on the HCFA-1500 billing form. You can also enter an "S" here, telling PTOS to bill the charge to the secondary insurance but not the primary.

CO-PAY -will only appear if you selected CO-PAY BILLING **"YES"** for this patient on the second

Patient Data Screen. It will show the co-pay amount you have entered in the patient file. If CO-PAY has been set to yes, but no co-pay amount has been entered in the patient file, then the co-pay amount entered in the PROCEDURE CODE will be selected. You can type a different amount, including **"0",** under CO-PAY if it needs to be customized for this entry.

DIAGNOSIS -The patient's diagnoses are shown here and the DEFAULT DX is pulled in. It can be changed if desired. This field is only used in box 24E of the HCFA 1500, and can be **"1", "2", "1,2", "2,4", or "2,3,4"** in reference to which of the patient's diagnoses the visit applies to. It could also be the ICD9 code of the applicable diagnosis, or you could just enter **"ALL".**

MODIFIER – You can assign a modifier in the PROCEDURE CODE to print in box 24D of the HCFA-1500. You can also enter a modifier here which will override the procedure code.

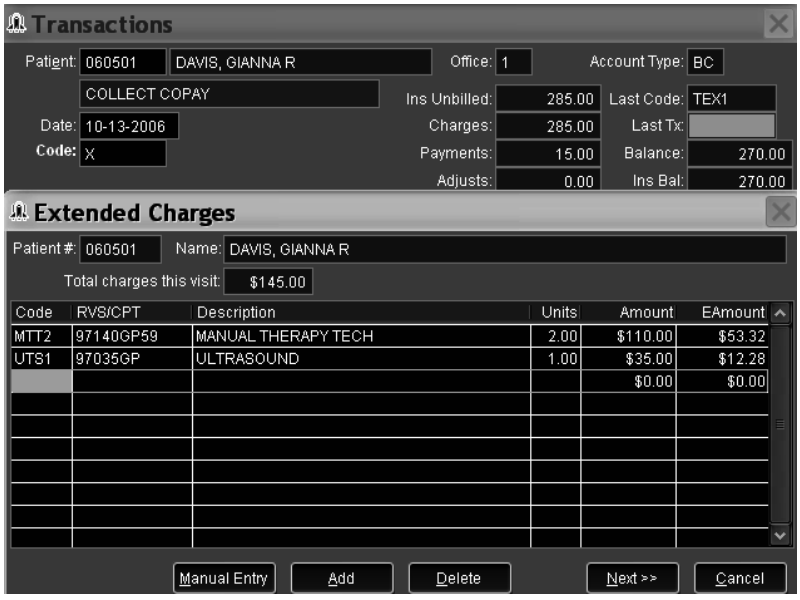
All of the above entries are optional, based on the requirements of specific insurance carriers. When finished with this screen, click POST. The charge will be posted and PTOS returns you to the main TRANSACTION screen.

LAST VISIT

Frequently, the patient will have the same treatment from one visit to the next. After you select CHARGE from the main TRANSACTION screen, a LAST button appears which you may select. Clicking LAST will list the codes posted for the last visit. Up to five separate procedure codes and or "I" codes (as explained later) will be listed. PTOS will then ask if you wish to POST the same codes, or QUIT to return to the main TRANSACTION screen. *****NOTE*** Transactions must be run through the 'DAILY TRANSACTION REPORT before they will appear under LAST VISIT.**

EXTENDED CHARGES

Sometimes you may want to post several procedure codes for one visit. You may also have a unique entry for which there is no procedure code. Select EXTEND from the main TRANSACTION screen and a grid appears allowing you to post multiple procedure codes for the day's entry. You can also post an "I" code by either typing "I" as the code or by clicking the



MANUAL ENTRY button (see "I" CODE description below) .
If you make a mistake, move under the **CODE** you wish to delete and click **DELETE**. You can then enter the proper code. When finished, click **NEXT** and the same additional information as in single **CHARGE** entry is displayed.

QUICK CHARGES
The final method to enter charges is through selecting **QUICK CHARGES** from the **SEARCH** screen. This displays a grid similar to **EXTENDED** above, however not only can you post several different codes for one patient, you can also change the date and account number. This allows you to post several days entries for one patient, charges for several patients on one day, or several charges for different patients on different days. You can also use the **LAST** button to pull in the codes used in the previous visit.

INDIVIDUAL "I" CODES
Sometimes you won't have a procedure code that describes a specific treatment. Enter "I" as the code for the charge and PTOS lets you enter the CPT code, a unique description, units, amount and the "expected amount".

MILEAGE PROCEDURE CODES
If you bill for mileage, usually for a contract or home health, there is a special type of procedure code that can automatically calculate the fee. Mileage codes begin with "ZMI" as explained in the **UPDATE PROCEDURES CODES** section. The per mile fee is the AMOUNT entered in the PROCEDURE CODE. When you post the mileage procedure code, enter the number of miles driven in the **DIAGNOSIS** field. PTOS will multiply this number by the per mile fee and post an "I" code to the patient account with the proper description and charge.

BILLING CODE TRANSLATION
Billing code translation is explained under **UPDATE PROCEDURE CODES**. If you elected to use the option, when you post a charge, don't include the first character of the code. This is the character that describes the coding type. For example, if "HUM" is used for Hot Packs, Ultrasound, and Massage, you would have a code "BHUM" for Blue Cross and "PHUM" for Prudential. Typing "HUM" as the procedure code would pull in "BHUM" for any accounts whose primary insurance code starts with a "B" (Blue Cross). If the first digit of the primary carrier code was **"P",** such as **"PRU"** for Prudential, posting **"HUM"** would cause **"PHUM"** to be posted.

*****NOTE *** If BILLING CODE TRANSLATION has been selected, and you use the F2 KEY to pull up a PROCEDURE CODE, then you will cursor down, highlight, and select the ACTUAL CODE you need. For example, select "RHUM", not "HUM".**

PAYMENTS AND ADJUSTMENTS

Once charges have been entered into the system, payments and/or credits can be applied to them. There are several methods for posting credits or payments.

LINE-ITEM -VS- BALANCE FORWARD -VS- DATE RANGE POSTING -VS- CO-PAY
The simplest method for posting payments is **"Balance Forward".** This means, when you post a payment or credit, instead of applying it to a specific charge, or group of charges, it is applied to the oldest balance automatically.

"Line-Item" posting allows 'you to break a payment up, and apply parts of it to specific charges. For example, a patient had a $60 charge on November 10th, and a $100 charge on November 15th. The insurance carrier sent a payment for $112, with an explanation of benefits indicating

that $45 of the payment applies to the first charge, and $67 to the second charge. Line-item posting allows you to pull up each charge and post the appropriate amount to it.

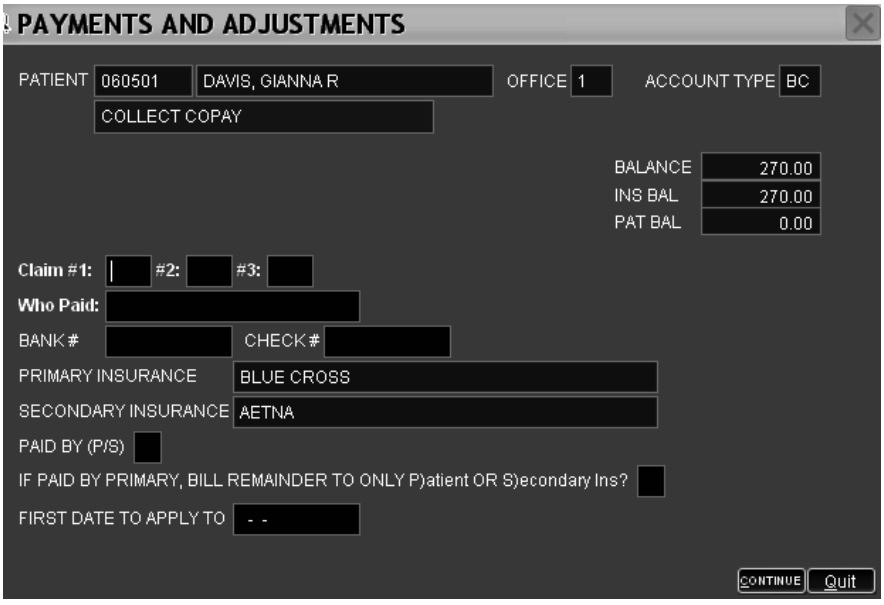
Line-item posting is more exact. It also means you need to take a little more time posting payments and credits, since you must indicate the amount applied to each charge. We have developed a unique method of posting payments for PTOS, called **"DATE RANGE POSTING".** As its name implies, a payment is distributed across a range of dates. PTOS calculates what percentage of the open charges for the date range is being paid, and automatically posts the appropriate amount to each charge. In the above example, if you post a $112 payment for the date range 11/10 to 11/15, PTOS would calculate that this equals 70% of the total charges and would apply $42 (70% of $60) to the first charge and $70 (70% of 100) to the second.

DATE RANGE POSTING offers the advantages of being almost as simple as BALANCE FORWARD POSTING, while being much more accurate in applying the payment. It is nearly as exact as LINE-ITEM POSTING, while involving much less work.

There is a fourth method of posting which applies only to patient payments. If you designated CO-PAY billing for the patient, on the PATIENT DATA screen, then a CO-PAY amount will be tracked for each charge. When you post a patient payment, select CO-PAY posting. PTOS will ask for a date range to be covered, similar to DATE RANGE posting. If there were three visits during the date range selected, with a CO-PAY amount of $5 per charge, PTOS would show an open CO-PAY amount totaling $15. If the patient paid $12, PTOS would apply $5 to each of the first two charges, and $2 against the third charge within the date range.

PAYMENTS

If you want to post an INSURANCE or PATIENT payment, click the PAY button on the main TRANSACTION screen. PTOS then asks if you wish to post a PATIENT or INSURANCE payment and whether to use B)alance forward, L)ine item, or D)ate range posting. If you select a BALANCE FORWARD insurance payment, the screen below appears.



CLAIM #- Up to three CLAIM NUMBERS which are being paid by this check can be entered. The claim number is generated by PTOS when the insurance claim is printed. All insurance claims

which have had no payments applied to them are then included on the Insurance Tracer Report (see MANAGEMENT REPORTS). If you intend to generate Insurance Tracer Reports, which are highly recommended for collections, you MUST fill out the CLAIM # when a payment is posted, or PTOS will have no way of knowing that the claim has been paid. To find the appropriate CLAIM NUMBER, double click in the CLAIM NUMBER field.

WHO PAID - Next you are asked for a description of WHO PAID, which could be **"pd. by Prudential"** You can type a description, or use PAYMENT/ADJUSTMENT CODES to pull in the payment descriptions. Using PAYMENT/ADJUSTMENT codes not only saves time in posting, but adds consistency when printing lists of payments or adjustments. The code can be typed in the WHO PAID box or can be pulled in with F2 KEY.

BANK # and CHECK # -The bank and check numbers are only necessary if you are having PTOS generate your bank deposit slips through the DAILY TASKS option. If you have PTOS generate your bank deposit slip, there is a special circumstance to be aware of. Sometimes, an insurance carrier will write one check to cover several accounts. You must then make sure to enter the same bank and check numbers in each of the accounts. Then, when the BANK DEPOSIT SLIP is printed, you will be asked if you want to SUBTOTAL BY CHECK.

PRIMARY/SECONDARY INSURANCE- The primary and secondary carriers are shown as a reference. Enter a **"P"** or **"S"** in the PAID BY field so that PTOS can track who made the payment.

AMOUNT -This is where you enter the amount of the payment.

LINE-ITEM INSURANCE PAYMENT

If LINE-ITEM is selected as the payment type, the same screen as on the previous page is shown, except instead of amount, PTOS asks:

IF PAID BY PRIMARY, BILL REMAINDER TO ONLY P)atient OR S)econdary INS? -If this is a primary insurance payment and you type "P", the charges we've just posted to, will only be billed on a patient statement in the future. If you enter "S", then the charges will be billed to the secondary insurance carrier and to the patient.

PTOS will also ask for the **FIRST DATE TO APPLY TO:**

After you enter the first charge date being paid by this check, a screen similar to the following page appears. All charges posted on or after the FIRST DATE TO APPLY TO are shown. There is room for eight transactions per screen. The first line for each charge shows the transaction date, procedure code and description, date billed to insurance and any co-pay amount. The POST field is where you enter the amount being paid against the charge. The second line shows the amount of the charge (AM), the expected amount (EX), any credits (CR), insurance payments (IP) or patient payments (PP) which have already been posted.

The third line of the charge description shows what you should be paid by the primary insurance. When you created the INSURANCE CODE, you specified a percent that the carrier normally pays when they are the primary insurance. In the example on the next page, it was 75%. PTOS then calculates that percent of the amount charged and displays it under charge (AM). The percent of expected amount is displayed under EXPECTED (EX). The amount being paid should equal one of these numbers. Also shown is the remaining balance.

Enter the amount being paid against the charge, or you can press <enter> to skip past the charge. As you enter an amount on the line, the total posted appears at the bottom left of the screen next to POSTED THIS PATIENT and POSTED THIS CHECK**. ***NOTE*** PTOS will automatically carry the check information if you wish to continue posting the same check to a different account.** When you reach the bottom of the screen, you can press N)ext screen to see more transactions, or P)revious to move backwards. ***NOTE ***When you skip to the next screen, the POST amounts for each line are transferred to the IP (insurance paid) field and the POST field is reset to zero on each individual line. The POST total at the bottom, however, continues to accumulate. If you then move back to the P)revious you can post an additional amount against the charge which is added to what you've posted.** You can also subtract an amount that has already been posted by entering a minus sign in front of the amount you're posting, for example -50.00.

Patient: 060501
DAVIS, GIANNA R
Office: 1
Account Type: BC
INS PAYMENT
COLLECT COPAY
06/10/12 PEV1 97001 PT EVALUATION COPAY 15.00 POST
AM 150.00 EX 65.14 CR 0.00 IP 0.00 PP 15.00 89.00
BALANCE 46.00
06/10/12 TEX2 97110 THERAPEUTIC EXERCIS COPAY 0.00 POST
AM 90.00 EX 57.00 CR 0.00 IP 0.00 PP 0.00 0.00
BALANCE 90.00
06/10/13 TEX1 97110 THERAPEUTIC EXERCIS COPAY 0.00 POST
AM 45.00 EX 28.50 CR 0.00 IP 0.00 PP 0.00 0.00
BALANCE 45.00
Amount Posted this Patient: $89.00
Apply Expected Amount
Post
Amount Posted this Check: $89.00
Pay Off Charge
Page: 1 of 1

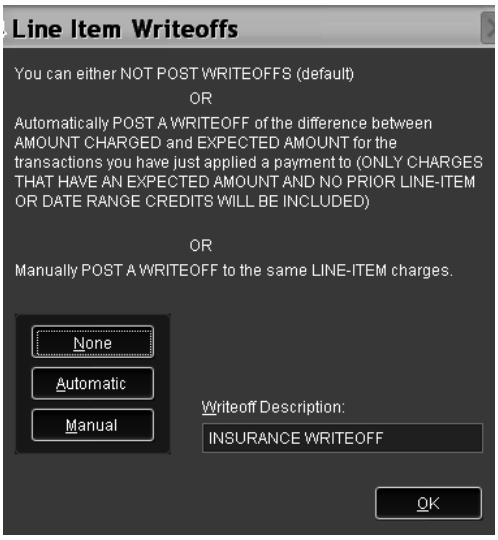
After you've finished moving through the screens of transactions to post the payment, click **POST**. At this point all balances are updated. There is also an entry automatically created that describes the payment or credit. This is your reference of what was posted. The transaction is posted with a "D" (debit) code and has a description that would look like this:

"Blue Cross pd. $119.00 FOR 10/13-10/13/6"

PTOS takes what you've entered under WHO PAID, in this case **"Blue Cross",** and adds the description **"pd. $119.00 FOR 07/10-07/17/3"** which is calculated as the payment is posted.

The system then displays a LINE-ITEM WRITEOFF screen shown on the next page. This lets you post a write-off to the charges you just recorded a payment against. You can click NONE (the default) and skip posting a write-off. You can click MANUAL, and the same range of dates will be pulled up on a screen similar to the above. You can then enter an amount to write-off against each charge.

If you select AUTOMATIC, PTOS will calculate the difference between the amount posted and the expected amount of each charge you posted the payment against. The system will show the **TOTAL CHARGES** and **EXPECTED AMOUNT** on these charges, and the **AMOUNT TO WRITE OFF** on these charges. If you select **OK**, PTOS will automatically write-off the difference. With either a MANUAL or AUTOMATIC write-off, you can enter a WRITEOFF DESCRIPTION, or use the F2 key to pull in a standard description from the PAYMENT/ADJUSTMENT CODE library.

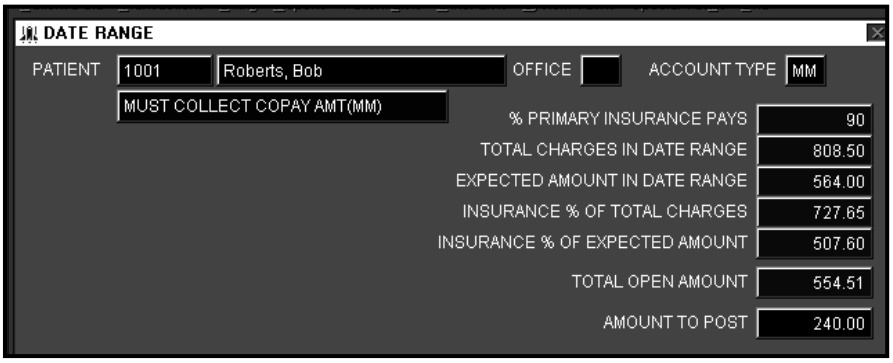

Line Item Writeoffs
You can either NOT POST WRITEOFFS (default)
OR
Automatically POST A WRITEOFF of the difference between AMOUNT CHARGED and EXPECTED AMOUNT for the transactions you have just applied a payment to (ONLY CHARGES THAT HAVE AN EXPECTED AMOUNT AND NO PRIOR LINE-ITEM OR DATE RANGE CREDITS WILL BE INCLUDED)
OR
Manually POST A WRITEOFF to the same LINE-ITEM charges.
None
Automatic
Manual
Writeoff Description:
INSURANCE WRITEOFF
OK

DATE RANGE INSURANCE PAYMENT

This is similar to LINE-ITEM, only instead of FIRST DATE TO APPLY TO, PTOS will ask:

FIRST DATE TO APPLY TO
LAST DATE TO APPLY TO

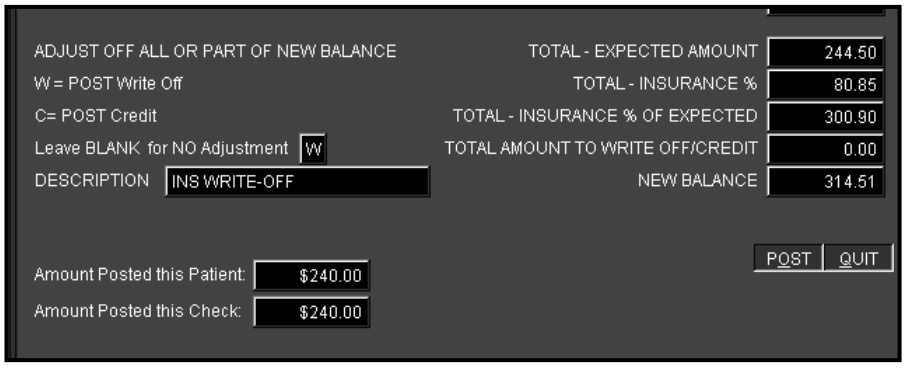
As with Line-item, enter WHO PAID, the first date to apply it to, and the last date the payment covers. PTOS will calculate the balance that remains for the period specified and display it with other internal calculations in the format below.



Let's go over what these totals mean. When you created the INSURANCE CODE, you specified a percent that the carrier normally pays when they are the primary insurance. In the case above, it was 90%. PTOS displays the percent you've entered, then shows the total charges for the date range you've selected. When you created the procedure code, you entered the amount you expect to receive (as opposed to what you bill). The total expected amount is also displayed.

PTOS then multiplies and displays the insurance percent of total charges and expected amount. The insurance payment should be equal to, or between these two numbers. If it's not, they probably disallowed some charges and depending on the difference, you may want to check into why there is a discrepancy. If this seems complicated at first, don't worry. It's only meant as an additional guide to you and is not required to take advantage of DATE RANGE posting.

The next line shows the total open amount in the date range. In many cases, this will be equal to the total charges. If, however, payments or credits have been already posted, the open amount could be lower. Finally, PTOS asks you to enter the AMOUNT TO POST. Enter the amount of the check, and PTOS distributes it across the open charges, performs more calculations and asks if you want to adjust off all or part of the balance. If you respond yes, the following screen appears.



This new addition to the DATE RANGE posting screen shows the balance after $240.00 was applied to the open amount of $544.51. These calculations show possible amounts to be adjusted. You may want to adjust off the difference between the total charges and the expected amount, the difference between total charges and the percent the insurance should pay, or the difference between total charges and the insurance percent of the expected amount. Again, these are just calculations to help guide you. You can enter any AMOUNT TO WRITE OFF/CREDIT, or you can change your mind and leave the amount blank so that no adjustment is posted. PTOS will show the new balance after subtracting the adjustment amount. The system also asks for a DESCRIPTION of the credit, just as if you were posting a **"C"** or **"W"** adjustment.

If there is still an open amount after the adjustment was posted, or if you decide not to post an adjustment, the following appears. This allows you to transfer the balance to the patient or the secondary insurance.

BILL REMAINDER TO ONLY P)atient OR S)econdary Insurance?

Next, select **POST** or **QUIT** to post the entries or quit without posting any of the entries..

CREDITING AN INSURANCE PAYMENT TO PATIENT DEDUCTIBLE
If an insurance claim has had no payments made on it, the claim will continue to print on the INSURANCE TRACER report. Sometimes, the insurance will send an EOB indicating that the claim was applied to the patient's deductible. You can mark the claim as having been applied to the deductible by using the FIND option (as explained on the following pages) to find the claim. If the claim has had no payments posted against it, the following line will appear on the screen:

APPLY THIS CLAIM TO DEDUCTIBLE (YIN)
By clicking MODIFY and answering YES, this will be no longer considered an OPEN claim.

PATIENT PAYMENTS
The process of posting Balance Forward, Line-item and Date Range patient payments is identical to posting insurance payments with a couple of simple exceptions. There are no CLAIM #'s to apply the payment to, and no PRIMARY or SECONDARY insurance information is displayed. There is also one additional method of patient payment posting; CO-PAY PAYMENTS.

CO-PAY PAYMENTS
If there is a co-pay for visits, you should so indicate on the **PATIENT BILL SCREEN**. PTOS then tracks the open co-pay amount of each charge. When you select CO-PAY payment posting, the system functions the same as DATE RANGE posting, except the TOTAL OPEN AMOUNT is the outstanding co-pay amount for the date range you've selected. You then enter the AMOUNT TO POST and PTOS applies it to open co-pay amounts starting with the oldest open charge.

ADJUSTMENTS
There are three types of adjustments, PATIENT CREDITS, INSURANCE WRITE-OFFS AND DEBITS, as described below.

PATIENT CREDITS
A credit transaction reduces the balance owed by the patient. Examples are a bad debt write-off or a professional courtesy discount. A credit is different from a payment in that no money is received. To enter a credit, click **ADJUST** on the main TRANSACTION screen. PTOS then asks if you wish to use B)alance forward, L)ine item, or D)ate range posting. These function the same as described above for payments.

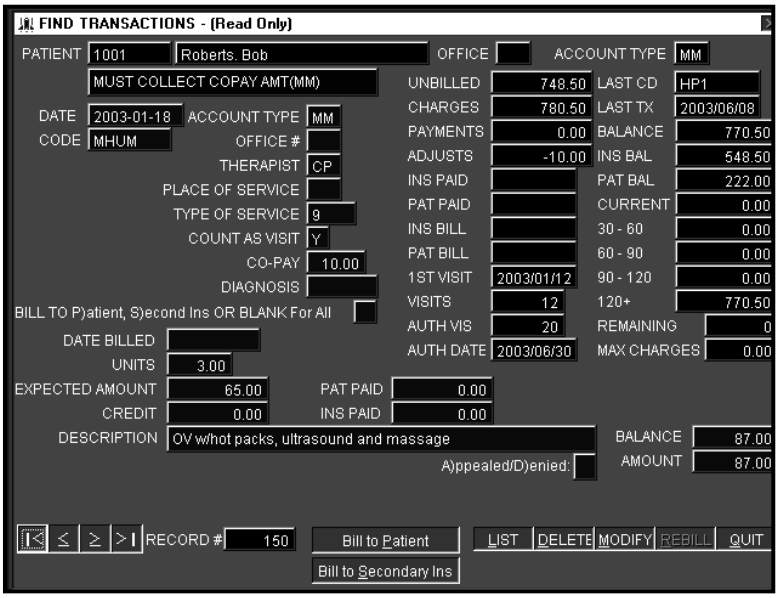
INSURANCE WRITE OFF
This has the same affect as a patient credit in reducing the balance owed, but it is applied to the insurance portion of the bill instead of the patient portion. To enter an insurance write off, use **"I".** You can then select Balance forward, Line-item or Date range posting, which work the same way as patient credit posting.

DEBIT
A debit entry increases the amount in the patient balance. It is different from a charge in that it doesn't represent a treatment. A finance charge, for example, is posted as a debit. **A DEBIT WILL APPEAR ON THE PATIENT STATEMENT BUT** N**OT ON THE INSURANCE CLAIM.** It is considered a charge payable by the patient, not the insurance. When posting a payment to a debit, it should be posted as a Balance Forward patient payment. You can't apply a Line-item or Date Range payment to a debit.

To enter a Debit, click **DEBIT** on the TRANSACTION screen and enter the description and amount. A debit could be used to add interest to an overdue balance, or to reverse an overpayment. A DEBIT is also posted automatically by PTOS for some functions. When you post a Date Range or Line-item payment or adjustment, or when a patient statement or insurance claim is sent, PTOS creates a DEBIT to describe the transaction.

FINDING A TRANSACTION

At times you may want to review or modify transactions which have already been posted. When in the main TRANSACTIONS screen, enter the first date you wish to view. Click **FIND** or Press ALT + F. If a transaction was entered on or after the date requested, it will be summarized on the



screen (to find the first entry for the patient, just click LIST). The transaction will appear in the above format:

Different information is shown, depending on the type of transaction. The above example is a CHARGE. If the transaction has already been billed to an insurance carrier, the billing date is shown. If Line-item or Date-range payments or credits have been applied, the amounts paid or credited will be indicated. CO-PAY is included along with the remaining BALANCE on the charge after applying any Line-item or Date Range credits or payments. If payment on the charge has been denied by insurance, you can mark it as **APPEALED** or as **DENIED**. To view entries from previous or following days, click the VCR buttons.

BILL PATIENT NOW
If, while reviewing transactions, you wish to produce a patient statement for the account, click this button.

BILL TO SECONDARY INSURANCE
If you wish to transfer the balance on the charge to the secondary carrier, click this button.

REBILL
If the transaction has been billed to an insurance carrier, and you wish to rebill this one particular charge, click **REBILL.** This removes the BILLED DATE and adds the amount into UNBILLED CHARGES. See **"Patient and Insurance Billing"** for a more detailed explanation of rebilling one or a group of charges.

MODIFY
To maintain the integrity of data entry and audit lists, not all data in a transaction can be modified. There are, however, some fields that you can revise. If you click **MODIFY**, in a "charge" entry such as the one shown above, the following fields can be changed:

THERAPIST	**PLACE OF SERVICE**	**TYPE OF SERVICE**	**VISIT (Y/N)**
DIAGNOSIS	**BILL TO PATIENT/SECONDARY/ALL**	**EXPECTED AMOUNT**	**CO-PAY**
OFFICE #	**ACCOUNT TYPE**	**APPEALED/DENIED**	

DELETING A TRANSACTION
If a transaction has been entered incorrectly, and the incorrect data is in a field that CANNOT be

modified, such as patient number, date, or code, it must be deleted and re-entered properly. This prevents any accidental or unauthorized changes to patient charges or payments. First, FIND the incorrect entry, then click **DELETE**. If an entry is deleted in this manner, the patient balance is adjusted immediately.

When you delete a transaction that has already been run through Daily Tasks, the deleted transaction will appear as a **"Newly Deleted Transaction"**, so that it will print on the Daily Transaction Report as an audit of deleted entries.

If you need to delete a CHARGE that has had a Date Range or Line-item payment or credit posted to it, the amounts under CREDITED, INSURANCE PAID and PATIENT PAID must first be reversed. Otherwise, your payments or adjustments would be out of balance. To do this, either delete the DATE RANGE or LINE-ITEM payments (or adjustments) that posted an amount to the charge, or post a NEGATIVE Line-item entry to the CHARGE as described below.

DELETING DATE-RANGE OR LINE-ITEM ENTRIES

If you want to delete a LINE-ITEM or DATE-RANGE payment or adjustment, it can become a little more involved. When you posted the payment or adjustment, PTOS put the amount paid or credited in the INSURANCE PAID, PATIENT PAID, or CREDIT fields of the charge being paid or credited. If, for example, a Line-Item insurance payment was incorrect you must first reverse the entry in the INSURANCE PAID field. There are two ways of accomplishing this.

One method is to **"FIND"** the LINE-ITEM payment. Click **DELETE** and PTOS will automatically reverse the payment out of each charge that it was applied to and delete the Line-Item DEBIT description entry. You can the post a corrected payment. This is the simplest approach and will be used in most cases.

The second method is to REVERSE the payment by posting a NEGATIVE Line-Item payment to the charge that is equal to the positive amount already posted. To do this, start by telling PTOS to post an insurance or patient payment or credit. Select Line-Item even if it was originally posted using Date Range. Enter the first date affected by the error. When the charge is pulled up on the screen, enter a NEGATIVE AMOUNT equal to the amount to be reversed. Skip to the next charge affected by the deletion and continue to apply negative amounts until all entries affected by the error have been reversed.

As we covered before, when LINE-ITEM or DATE RANGE payment or credits are posted, there is a DEBIT automatically created by PTOS that explains the payment with a description like "Blue Cross pd. $221.00 for 07/10-07/17/4". That debit MUST also be deleted. When you posted the negative LINE-ITEM payment to reverse the error, this also creates a DEBIT stating "Blue Cross pd. $-221.00 for 07/10-07/17/4". This DEBIT also should be deleted.

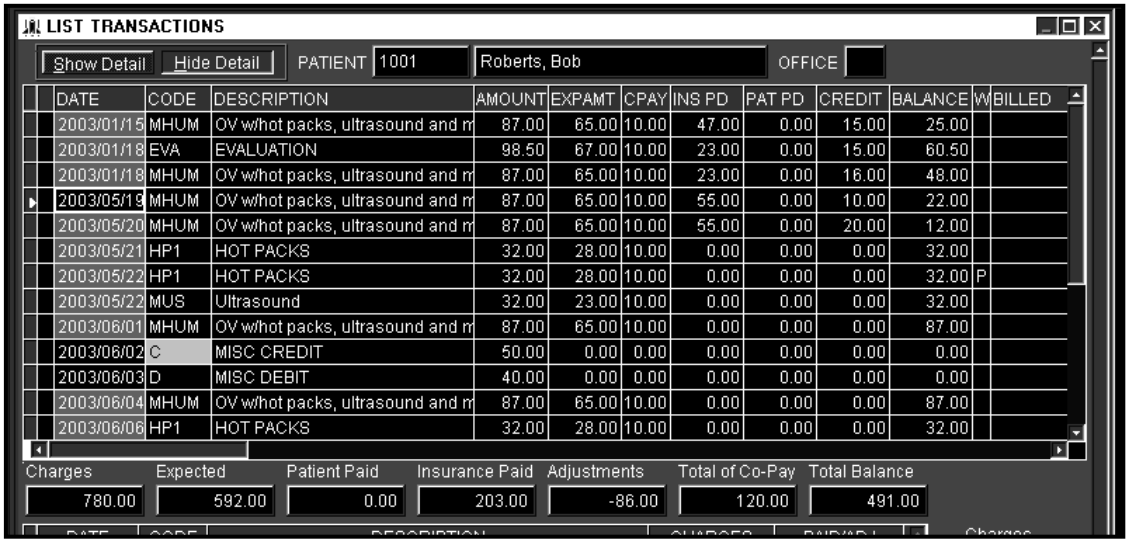
When you delete the DEBIT for the NEGATIVE LINE-ITEM PAYMENT to reverse the error, PTOS asks if you want to "AUTOMATICALLY REVERSE" the entries. Normally, you would want the entries reversed but in this case you DO NOT (since you already reversed them individually). If the entries are reversed, you will have undone the process of deleting an erroneous DATE RANGE or LINE-ITEM entry.

LIST TRANSACTIONS

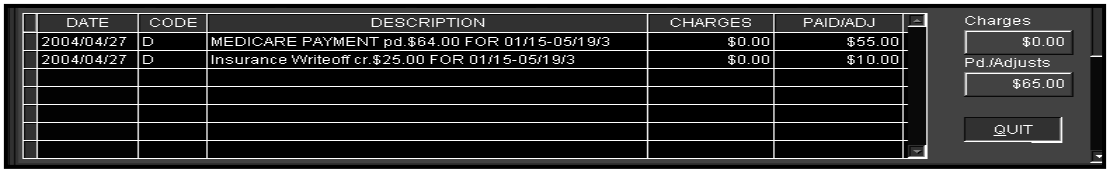
This option lists and totals all transactions for a patient, and is useful in answering inquiries or auditing entries for an account. Different types of transactions appear in different colors to make viewing easier. Charges are displayed in **GREEN**, payments are **YELLOW**, credits are **RED** and debits are **WHITE**. Just click LIST in the main TRANSACTION screen.

The list shows information about each transaction as well as total charges, expected amounts, payments and adjustments for the patient. As you move down the screen, the balance, charge amount and payment/adjustment total is shown at the right of the screen for the highlighted charge. You can use the arrow buttons in the LIST BOX to see more information, and **if you click in the far left box, PTOS will go into FIND mode and take you to the FIND screen for the entry.**

Note the **BILLED** column. If a charge has been billed to the insurance, the bill date is entered here. If the entry is a payment, the **BILLED** column shows the **CHECK NUMBER**.



If you want to see all payments and adjustments that have been made on a specific charge, click the **SHOW DETAIL** button at the top left. A DETAIL box will open showing all activity on the transaction. The screen below shows detail on the charge from May 19th. It indicates that a payment and write-off were posted, and that $55 of the payment was applied



ENTERING BEGINNING PATIENT BALANCES

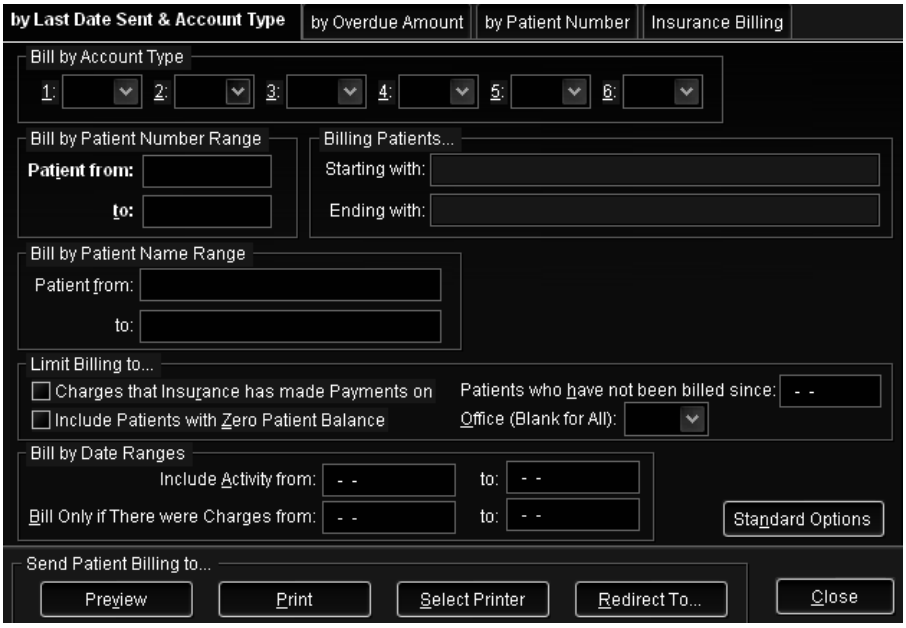
When you first install PTOS, you need to post the patients' current balances into the system. The simplest method is to use a DEBIT to each account, with the description **"Balance Forward"** and the amount of the patient's current balance. By entering all patients' current balances in this manner, your accounts receivable totals will be accurate from the start.

The approach above gives an accurate balance, but does not let you *see* the total charges, adjustments or payments made on each account. A second method is to take total charges, payments, and debit and credit adjustments for each patient, and post the totals into PTOS. If total charges were $1200.00, post an "I" code as explained above. If the patient has paid $300.00, post a patient payment for $300.00. Post any insurance payments, credits, write-offs, or debits in the same fashion.

*****NOTE*** If you use an "I" code to post total charges to date, these MUST be marked as having already been billed, or the "I" code will be rebilled to the insurance.** To mark the "I" code as having been billed, go into the SPECIAL TASKS menu, select SEND LETTERS and type "X" as the selection. This "hidden' option marks all charges in the system as having been billed and should only be run once, after all beginning balances have been entered.

4. PATIENT BILLING

Billing is broken into two categories; patient or insurance billing. Both are flexible and can be accomplished in a variety of ways. The screen below shows the Patient Billing selection which is displayed when PATIENT BILLING is selected from the task bar.



There are three different ways of generating statements; by Last Date Sent & Account Type, by Overdue Amount, and by Patient Number. The screen above shows the **selection BY LAST DATE SENT & ACCOUNT TYPE.**

ACCOUNT TYPES -First, enter up to six account types to bill. All patients in the selected categories will receive statements. This is the most flexible format for billing. If you want to bill only Medicare with Medicaid co-pay, type **"MM"** for account type. If you want all Medicare, whether they are **"MM", "MP",** or any other **"M"** account, simply type **"M ".** This means, bill any patients whose first character is **"M".** If you want ALL account types, just leave the field blank.

BILL BY NUMBER OR NAME RANGE -If you're printing statements in Patient Number Order, (explained in STANDARD OPTIONS below), a range of patient numbers can be specified to bill from and through. This allows billing for a single location, or other grouping of patients. It can also be used if some statements are lost, damaged or destroyed, and you need to rebill a group. If you've selected the statements to print in Alphabetical Order, then you want to specify a starting and ending patient last name, either to group the patients, or re-run a set of lost or damaged bills.
LIMIT BILLING TO…

CHARGES THAT INSURANCE HAS MADE PAYMENTS ON -Checking this box will bill only charges that an insurance carrier has already made payments against or charges that have had "WHO TO BILL" marked as "P" (bill to patient). A Certified Rehab Agency, for example, may only bill the patient for a charge after Medicare has made a payment against that charge. (This option can only work if insurance payments are posted using the Line Item or Date Range format).

PATIENTS WHO HAVE NOT BEEN BILLED SINCE -By typing the date to bill from, any patients who have not received a statement since that date will be selected.

INCLUDE PATIENTS WITH ZERO PATIENT BALANCE -PTOS will not print a statement for a patient with a **"ZERO"** or credit balance unless you tell it to. Checking this box allows statements to be generated, even if nothing is owed by the patient. Normally, if the patient portion of the balance is zero, you don't want to send a statement. Sometimes you may want to send a statement, either as a reference to the patient as to their account status, or when REMOVING OLD ACCOUNTS. When an account is closed you can REMOVE the patient, which clears them off the active system. Before REMOVING OLD ACCOUNTS, you can change the ACCOUNT TYPE to **"ZZ",** then run statements for all **"ZZ"** patients, to be placed in their chart.

OFFICE TO BILL -If you've separated your accounts into different offices, you can run bills for a specific office.

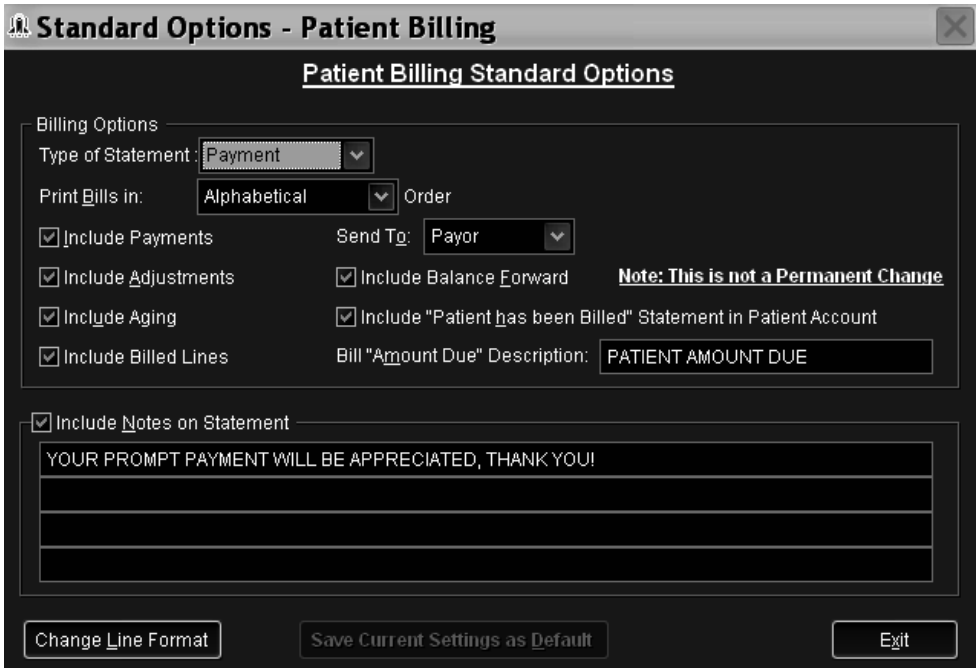
BILL BY DATE RANGES

INCLUDE ACTIVITY FROM-TO -If a patient has been treated over several months, you may not want all activity listed, only the last month or so. You can select which dates to include on the statement by filling out this line. For example, FROM **"2004/07/01"** through "2004/08/31" will bill only July and August activity. Leaving these two fields blank will cause all transactions to be listed, not just those for the current month. This provides the patient with a complete, concise bill.

BILL ONLY IF THERE WERE CHARGES -One billing technique that many practices find effective is to bill active patients for their portion, of charges on a weekly basis. Inactive accounts can then be billed monthly. By filling out the FROM and TO dates, you can print statements only for patients who had new charges during that period.

The above options allow you to specify which groups of patients should receive statements. You only need to fill out the options that you require to qualify the group of patients to be billed. If you want statements printed for all patients, including all activity since they've started treatment, just click **PRINT** when the above Billing Screen appears. If you want all patients to be billed, regardless of account type, but only for the last month's activity, don't fill in any of the six types, just fill out the **"INCLUDE ACTIVITY FROM -TO"** line.

The final option on this screen is **"STANDARD OPTIONS".** These are settings that you normally set once and won't change from one billing run to the next. The options on the above screen, such as date range to print, do change from one billing cycle to the next.


Standard Options - Patient Billing
Patient Billing Standard Options
Billing Options
Type of Statement : Payment
Print Bills in: Alphabetical Order
Include Payments
Send To: Payor
Include Adjustments
Include Balance Forward
Note: This is not a Permanent Change
Include Aging
Include "Patient has been Billed" Statement in Patient Account
Include Billed Lines
Bill "Amount Due" Description: PATIENT AMOUNT DUE
Include Notes on Statement
YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!
Change Line Format
Save Current Settings as Default
Exit

The first option is type of statement. There are five formats available for patient statements; "Summary", "Detailed", "Co-Pay" , "Payment" and "Graphical". The most common format is Summary, and sample Summary and Detail statements are shown on the following pages. All statement formats include DATE, DESCRIPTION and CHARGES columns. If Detail Statement is selected, the description of a CHARGE transaction comes from the same lines of the PROCEDURE CODE used on the Insurance Claim. This level of detail is rarely needed. The remaining statement types use the Statement Description Line from the procedure code. On a "Payment" statement, payments are separated into Insurance Paid and Patient Paid columns. This is simply an optional format to the Summary Statement if you wish to break out the source of payments. A "Co-Pay" statement is similar, with a Co-pay field added. The Graphical option is our newest patient statement, this option will include DATE, CPT CODE, DESCRIPTION, CHARGES, PATIENT AMOUNT, PATIENT PAYMENTS/CREDIT, INSURANCE PAYMENT/CREDIT and OPEN BALANCE and at the bottom of the statement has fields for the patient to fill in if paying by credit card.

Following the CHARGE column on the Detailed and Summary Statements are the PAYMENT and ADJUSTMENT columns. If a Line Item or Date Range payment or adjustment was entered against a charge, the amount paid or credited will print here, next to the charge they were applied to. The running balance is then calculated after each entry and aged amounts and balance due are shown at the bottom. If deductible and/or percent to bill patient amounts were specified in the Patient Data Screen, or if co-pay amounts have been posted against charges, PTOS will calculate patient responsibility. PTOS then subtracts patient payments and credits and will show the amount to be remitted as the "AMOUNT DUE" total.

*****NOTE***IF YOU HAVE FILLED IN THE "PAYMENT PLAN AMOUNT" FIELD IN THE PATIENT FILE, THAT IS THE AMOUNT WHICH WILL PRINT AS THE "AMOUNT DUE". IF NOT, THEN THE PATIENT PORTION IS CALCULATED AS FOLLOWS:**

All debits are calculated as of the patient's portion (this will include the **"Balance Forward"** debit when you initially install PTOS, so the amount YOU consider to be the patient portion may not be what is shown. There is no way PTOS can know what part of a **"Balance Forward"** DEBIT applies to the patient).

Charges are computed as follows: First, total charges are compared to the deductible. If charges are less than the deductible, the patient is billed for 100% of the charges. If total charges exceed the deductible, the patient portion is calculated as 100% of charges UP TO THE DEDUCTIBLE, and the PERCENT you entered as the patient portion of the bill, is multiplied against all charges in excess of the deductible. If you have specified **"CALC % OF EXPECTED AMOUNT"** on the Patient profile, PTOS will multiply the PERCENT against the EXPECTED AMOUNT of each charge. If CO-PAY BILLING was selected, then the deductible is calculated and the co-pay amount of each charge is added after the deductible has been reached. If the balance on the charge has been transferred to the patient by marking "WHO TO BILL" with a "P", then the patient is responsible for the remainder on the charge.

All **"C" patient** credits and **"S"** patient payments are then credited against the patient portion of the bill, the result of all the above being the AMOUNT DUE total. It's possible for the AMOUNT DUE total to be printed as a negative number (a credit balance). This would happen if you have entered zero as the PERCENT TO BILL PATIENT in the Patient Data File, and then you've posted patient payments or credits, indicating to PTOS that the patient has paid more than they were responsible for.

SUMMARY STATEMENT

PHYSICAL THERAPY CLINIC
8686 BEVERLY BLVD,
LOS ANGELES, CA 90048
(213) 550-7777
FED TAX ID# 95-1762531

THOMAS ADAMS, PT

STATEMENT DATE: 10/27/2006
PATIENT: GIANNA R DAVIS
INJURED: 10/01/2006
PHYSICIAN: AMAYA CELESTE

DAVIS BRUCE
456 ELM ST
SPOKANE WA 99026

EMPLOYER: APS ADVANCED PRACTICE SYSTEM
18455 BURBANK BLVD., STE 408
TARZANA CA 91356

ACCT 060501 BC TA DIAGNOSIS: PAIN IN JOINT SHOULDER

DATE	DESCRIPTION	CHARGES	PAID	ADJUSTS	BALANCE
	BALANCE FORWARD				0.00
10/13/06	97001 PT EVALUATION	150.00	80.14	-69.86	0.00
10/13/06	97110 THERAPEUTIC EXERCISE	45.00	28.50	-16.50	0.00
10/13/06	PAT CHECK PD.$15.00 FOR 10/13-10/13/6				
10/15/06	97110 THERAPEUTIC EXERCISE	90.00	72.00	-18.00	0.00
10/15/06	97035 ULTRASOUND	35.00	12.28	-22.72	0.00
10/26/06	CA BLUE CROS billed 320.00 for 10/13-10/15/6				
10/26/06	97110 THERAPEUTIC EXERCISE	135.00	15.00		120.00
10/26/06	97140 MANUAL THERAPY TECHNIQUES	55.00			175.00
10/26/06	PAT CHECK PD.$30.00 FOR 10/15-10/26/6				
10/27/06	PRIMARY INS PYMT pd.$162.92 FOR 10/13-10/15/6				
10/27/06	Insurance Writeoff cr.$127.08 FOR 10/13-10/15/6				
	TOTALS	510.00	207.92	-127.08	

YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!

CURRENT	OVER 30	OVER 60	OVER 90	OVER 120	PATIENT AMOUNT DUE	0.00
175.00	0.00	0.00	0.00	0.00		

DETAILED STATEMENT

PHYSICAL THERAPY CLINIC
8686 BEVERLY BLVD.
LOS ANGELES, CA 90048
(213) 550-7777
FED TAX ID# 95-1762531

THOMAS ADAMS, PT

STATEMENT DATE: 10/27/2006
PATIENT: GIANNA R DAVIS
INJURED: 10/01/2006
PHYSICIAN: AMAYA CELESTE

DAVIS BRUCE
456 ELM ST
SPOKANE WA 99026

EMPLOYER: APS ADVANCED PRACTICE SYSTEM
18455 BURBANK BLVD., STE 40R
TARZANA CA 91356

ACCT 060501 BC TA DIAGNOSIS: PAIN IN JOINT SHOULDER

DATE	RVS/CPT	DESCRIPTION	CHARGES	PAID	ADJUSTS	BALANCE
		BALANCE FORWARD				0.00
10/13/06	97001GP	PT EVALUATION	150.00	80.14	-69.86	
10/13/06	97110GP	THERAPEUTIC EXERCISE	45.00	28.50	-16.50	
10/13/06	PAT CHECK PD.$15.00 FOR 10/13-10/13/6					
10/15/06	97110GP	THERAPEUTIC EXERCISE	90.00	72.00	-18.00	
10/15/06	97035GP	ULTRASOUND	35.00	12.28	-22.72	
10/26/06	CA BLUE CROS billed 320.00 for 10/13-10/15/6					
10/26/06	97110GP	THERAPEUTIC EXERCISE	135.00	15.00		120.00
10/26/06	97140GP59	MANUAL THERAPY TECH	55.00			175.00
10/26/06	PAT CHECK PD.$30.00 FOR 10/15-10/26/6					
10/27/06	PRIMARY INS PYMT pd.$162.92 FOR 10/13-10/15/6					
10/27/06	Insurance Writeoff cr.$127.08 FOR 10/13-10/15/6					
		TOTALS	510.00	207.92	-127.08	

YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!

CURRENT	OVER 30	OVER 60	OVER 90	OVER 120	PATIENT AMOUNT DUE	0.00
175.00	0.00	0.00	0.00	0.00		

CO-PAY STATEMENT

PHYSICAL THERAPY CLINIC
8686 BEVERLY BLVD.
LOS ANGELES, CA 90048
(213) 550-7777
FED TAX ID# 95-1762531

THOMAS ADAMS, PT

STATEMENT DATE: 10/27/2006
PATIENT: GIANNA R DAVIS
INJURED: 10/01/2006
PHYSICIAN: AMAYA CELESTE

DAVIS BRUCE
456 ELM ST
SPOKANE WA 99026

EMPLOYER: APS ADVANCED PRACTICE SYSTEM
18455 BURBANK BLVD., STE 40R
TARZANA CA 91356

ACCT 060501 BC TA DIAGNOSIS: PAIN IN JOINT SHOULDER

DATE	DESCRIPTION	CO-PAY	CHARGES	ADJUSTS & INS PAID	PATIENT PAID	BALANCE
	BALANCE FORWARD					0.00
10/13/06	97001 PT EVALUATION	15.00	150.00	135.00	15.00	0.00
10/13/06	97110 THERAPEUTIC EXERCISE		45.00	45.00		0.00
10/13/06	PAT CHECK PD.$15.00 FOR 10/13-10/13/6					
10/15/06	97110 THERAPEUTIC EXERCISE	15.00	90.00	75.00	15.00	0.00
10/15/06	97035 ULTRASOUND		35.00	35.00		0.00
10/26/06	CA BLUE CROS billed 320.00 for 10/13-10/					
10/26/06	97110 THERAPEUTIC EXERCISE	15.00	135.00		15.00	120.00
10/26/06	97140 MANUAL THERAPY TECHNIQUES		55.00			175.00
10/26/06	PAT CHECK PD.$30.00 FOR 10/15-10/26/6					
10/27/06	PRIMARY INS PYMT pd.$162.92 FOR 10/13-10/1					
10/27/06	Insurance Writeoff cr.$127.08 FOR 10/13-10					
	TOTALS	45.00	510.00	-290.00	45.00	

YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!

CURRENT	OVER 30	OVER 60	OVER 90	OVER 120	PATIENT AMOUNT DUE	0.00
175.00	0.00	0.00	0.00	0.00		

PAYMENT STATEMENT

PHYSICAL THERAPY CLINIC
8686 BEVERLY BLVD.
LOS ANGELES, CA 90048
(213) 550-7777
FED TAX ID# 95-1762531

THOMAS ADAMS, PT

STATEMENT DATE: 10/27/2006
PATIENT: GIANNA R DAVIS
INJURED: 10/01/2006
PHYSICIAN: AMAYA CELESTE

DAVIS BRUCE
456 ELM ST
SPOKANE WA 99026

EMPLOYER: APS ADVANCED PRACTICE SYSTEM
18455 BURBANK BLVD., STE 408
TARZANA CA 91356

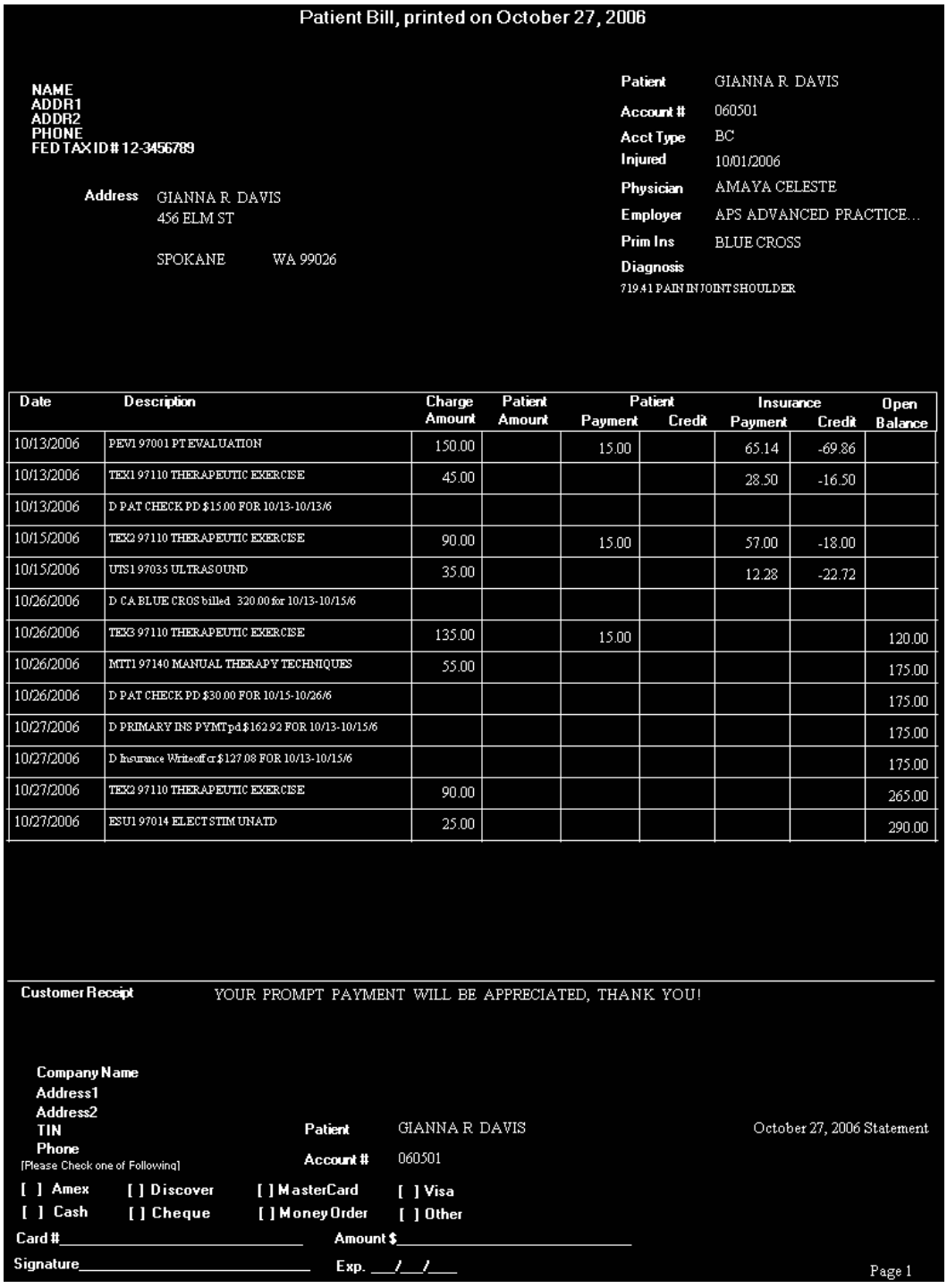
ACCT 060501 BC TA DIAGNOSIS: PAIN IN JOINT SHOULDER

DATE	DESCRIPTION	CHARGES	INSURANCE PAID	ADJUSTS	PATIENT PAID
	BALANCE FORWARD 0.00				
10/13/06	97001 PT EVALUATION	150.00	65.14	-69.86	15.00
10/13/06	97110 THERAPEUTIC EXERCISE	45.00	28.50	-16.50	
10/13/06	PAT CHECK PD.$15.00 FOR 10/13-10/13/6				
10/15/06	97110 THERAPEUTIC EXERCISE	90.00	57.00	-18.00	15.00
10/15/06	97035 ULTRASOUND	35.00	12.28	-22.72	
10/26/06	CA BLUE CROS billed 320.00 for 10/13-10/15/6				
10/26/06	97110 THERAPEUTIC EXERCISE	135.00			15.00
10/26/06	97140 MANUAL THERAPY TECHNIQUES	55.00			
10/26/06	PAT CHECK PD.$30.00 FOR 10/15-10/26/6				
10/27/06	PRIMARY INS PYMT pd.$162.92 FOR 10/13-10/15/6				
10/27/06	Insurance Writeoff cr.$127.08 FOR 10/13-10/15/6				
	TOTALS	510.00	162.92	-127.08	45.00

YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!

CURRENT	OVER 30	OVER 60	OVER 90	OVER 120	PATIENT AMOUNT DUE	0.00
175.00	0.00	0.00	0.00	0.00		

GRAPHICAL SUMMARY STATEMENT



Patient Bill, printed on October 27, 2006

NAME
ADDR1
ADDR2
PHONE
FED TAX ID # 12-3456789

Address GIANNA R DAVIS
456 ELM ST

SPOKANE WA 99026

Patient GIANNA R DAVIS
Account # 060501
Acct Type BC
Injured 10/01/2006
Physician AMAYA CELESTE
Employer APS ADVANCED PRACTICE...
Prim Ins BLUE CROSS
Diagnosis
719.41 PAIN IN JOINT SHOULDER

Date	Description	Charge Amount	Patient Amount	Patient Payment	Patient Credit	Insurance Payment	Insurance Credit	Open Balance
10/13/2006	PEV1 97001 PT EVALUATION	150.00		15.00		65.14	-69.86	
10/13/2006	TEX1 97110 THERAPEUTIC EXERCISE	45.00				28.50	-16.50	
10/13/2006	D PAT CHECK PD $15.00 FOR 10/13-10/13/6							
10/15/2006	TEX2 97110 THERAPEUTIC EXERCISE	90.00		15.00		57.00	-18.00	
10/15/2006	UTS1 97035 ULTRASOUND	35.00				12.28	-22.72	
10/26/2006	D CA BLUE CROS billed 320.00 for 10/13-10/15/6							
10/26/2006	TEX3 97110 THERAPEUTIC EXERCISE	135.00		15.00				120.00
10/26/2006	MTT1 97140 MANUAL THERAPY TECHNIQUES	55.00						175.00
10/26/2006	D PAT CHECK PD $30.00 FOR 10/15-10/26/6							175.00
10/27/2006	D PRIMARY INS PYMT pd $162.92 FOR 10/13-10/15/6							175.00
10/27/2006	D Insurance Writeoff cr $127.08 FOR 10/13-10/15/6							175.00
10/27/2006	TEX2 97110 THERAPEUTIC EXERCISE	90.00						265.00
10/27/2006	ESU1 97014 ELECT STIM UNATD	25.00						290.00

Customer Receipt YOUR PROMPT PAYMENT WILL BE APPRECIATED, THANK YOU!

Company Name
Address1
Address2
TIN
Phone
[Please Check one of Following]

Patient GIANNA R DAVIS
Account # 060501

October 27, 2006 Statement

[ ] Amex [ ] Discover [ ] MasterCard [ ] Visa
[ ] Cash [ ] Cheque [ ] Money Order [ ] Other

Card #_____ Amount $_____
Signature_____ Exp. ___/___/___

Page 1

PRINT ORDER

In addition to selecting the statement type, STANDARD OPTIONS allows you to select whether you want the statements printed in alphabetical order, or in account number order. You can also indicate what data to include on the statements.

INCLUDE PAYMENTS & ADJUSTMENTS

When sending a statement for a legal case, the attorney sometimes requests that no payments

(and/or) adjustments, appear on the statement. You have the option of indicating not to include payments, and/or not to include adjustments.

INCLUDE AGING
The patient statement normally includes a line at the bottom showing the aging of the account. You may want to suppress account aging, and can do so. The rationale is as follows: Some people like to show aging so the patient knows you are aware of the age of their account, and you know they have an old balance. Other people feel that if you show aging, it implies you are willing to carry an account for 30, 60 or 90 days before you really insist on payment.

INCLUDE BILLED LINES
The "HAS BEEN BILLED" entries showing when the patient or insurance were billed can be included on the statement.

SEND TO:
Normally, the statement is addressed to the payor. In some cases you may wish to send a statement to the patient as well. An example would be billing an attorney as Payor, and sending a second statement to the patient as a reference. You can also indicate that the statement should **be addressed to either the primary or secondary insurance carrier, if you wish to bill them using the statement format rather than an insurance claim.**

INCLUDE BALANCE FORWARD
If the patient has been treated over several months, and you are not printing the old charges, PTOS will normally bring the old balance forward and print it at the top of the statement. The Detailed statement example includes the BALANCE FORWARD, while it has been suppressed on the Summary statement.

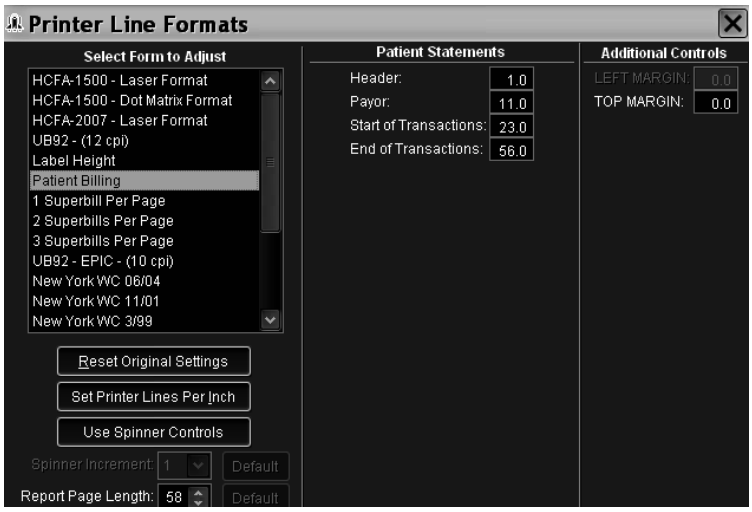
INCLUDE "PATIENT HAS BEEN BILLED"

When the patient is billed, PTOS asks if you wish to include a **"Patient has been billed"** statement in the patient account. This is a DEBIT transaction for the patient, automatically created by PTOS in a format which states who was billed, the amount billed and the dates of service billed, for example 'John **Jones billed $565.50 for 12/01 thru 06/30/4'.** This will appear on the patient statement and any transaction lists, and is VERY useful as a billing reference. *****NOTE *** If you are rebilling, you may want to suppress the "Patient has been billed" statement, so that the billing comment line is not duplicated.**

AMOUNT DUE DESCRIPTION
The "AMOUNT DUE" is the portion of the charges that the patient is responsible for. You can enter a description here such as "DUE FROM PATIENT", or any other description that suits your needs. ***NOTE*** If you leave this blank, no "AMOUNT DUE" total will print.

INCLUDE NOTES
When you set up ACCOUNT TYPE CODES, you are able to enter four lines of notes that will print at the bottom of the patient statement for all patients in the account type. You can override these notes by selecting INCLUDE NOTES ON STATEMENT (YES) and typing a different message.

CHANGE LINE FORMAT



Clicking this button calls the following screen, which permits you to adjust the statement to best fit your printer. Changing the HEADER and PAYOR lines adjusts how the statement will fit into a window envelope. If your printer has room for more transactions on a page, increase the END OF TRANSACTIONS line.
When you first use PTOS, set up these **"STANDARD"** options, and .make them **"permanent".** Then when you run different billings, you can make whatever modifications are desired. If in the future you want to make changes to the standard options permanent (as opposed to changing them for just one run), just answer YES to. **"MAKE OPTION CHANGES PERMANENT".**

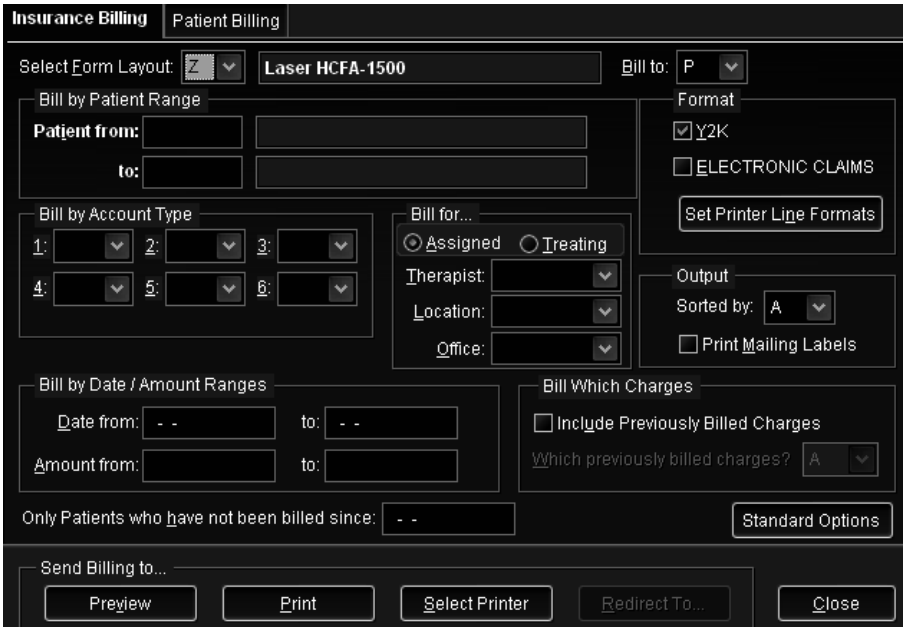
OTHER PATIENT BILLING OPTIONS

PATIENT BILLING BY OVERDUE AMOUNT
Patient billing by overdue amount lets you send statements to delinquent accounts. Select whether you want over 60, 90, or 120 day accounts, and if you only wish to include those who have made no payments since a date you specify.

*****NOTE*** if you select billing those over 60 days, only accounts whose OLDEST balance** is 60 days will be billed. Anyone with a balance over 90 or 120 will NOT be billed. This allows you to group billing and dunning notices to accounts that are a little past due (60 days), more delinquent (90 days), and very much past due (120 days).

PATIENT BILLING BY PATIENT NUMBER
The final option for patient billing is by patient number. This allows you to generate a statement for up to SIX patients at a time. Enter the patient numbers to bill and their names are pulled up as a reference. You can also use the HELP key if you don't know the patient's number. This statement option can be useful for printing statements to patients who have just been discharged.

5. INSURANCE BILLING



When you select INSURANCE BILLING, there are several options you can choose. The screen on the next page shows the criteria to create insurance forms. PTOS provides for several standard forms. The default form is the HCFA-1500. By selecting form "Z", the HCFA-1500 or “V”, the HCFA-2007 will be formatted to print on MOST laser printers. We also include both summary and "line-item" versions of the UB92 as standard forms. Depending on the state in which you are located, there may be other billing forms.
Select the claim form to be used. Then respond to any of the parameters that apply. Sometimes, a special form, or unique modifications of the HCFA or UB92 are required. We can customize most forms on a fee basis, if we don't already have it in our forms library. The fee is determined by the complexity of the form or modifications.

BILL TO - The default is to bill the primary insurance. You can also bill both primary and secondary at the same time, or select secondary billing after the primary has paid. If you select BOTH, first ALL primary claims will print, THEN claims for any secondary carriers will print. If you enter name and address. Information for a third insurance as the patient's PAYOR, select "X” to bill the payor.

FORMAT OPTIONS
On the right side on the INSURANCE BILLING screen are format options.

Y2K - This applies to either the UB92 or HCFA-1500. Checking this box will enable the printing digit years in all date boxes.

ELECTRONIC CLAIMS – If you have purchased the PTOS ECS interface option, checking this box will send billing output to the ECS transfer file for transmission to your ECS intermediary.

SET PRINTER LINE FORMATS - As every printer is somewhat unique, you may need to click on this selection to adjust where boxes print on your version of the insurance form.

BILL BY PATIENT RANGE - If you want to bill a specific patient number range, you can enter the range here.

BILL ACCOUNT TYPES -You can select only certain account types to bill. Up to six account types can be billed in a session. As with patient statements, if you only enter the first character of the account type, all account types with that first character will be billed. If you want all Medicare, whether they are “MM”, “MP”, or any other “M” account, simply type “M” This means, bill any patients whose first character in account type is “M”.

BILL FOR:

ASSIGNED OR TREATING THERAPIST TO BILL -This option will allow you to bill by the assigned therapist or the treating therapist and the ability to bill by an individual therapist.

LOCATI0N TO BILL -If you only want patients from a specific location (those whose account numbers begin with a specific character), enter the location.

OFFICE TO BILL -If you've separated your accounts into different offices, you can run insurance claims for a specific office.

OUTPUT - SORTED BY You can sort most insurance output by account number , patient name, account type, or insurance code.

PRINT MAILING LABELS If you check this box, after all insurance claims have printed, PTOS will stop and tell you to insert labels into the printer. The system will then print one label for each carrier that was billed.

BILL BY DATE/AMOUNT RANGES
DATE FROM – TO Normally PTOS will bill all charges which have not yet been billed to an insurance carrier (except those that have been marked “P” – only to be billed to the patient). If you only want a specific date range, you can enter it here.
AMOUNT FROM – TO Each carrier has different “Audit Levels” For example, a $300 claim may get only a quick look and approval by a claims clerk. A claim of $600 may get a detailed review, while the $1000 claim may go through several audit levels. Each step means a delay in payment and an increasing likelihood that fees will be reduced or disallowed. So you want to send in small claims frequently, rather than large claims once a month. At the same time, you don't want to send in too small of a claim, since it costs you time and money to produce, mail, and follow up on each claim you send.

By specifying amounts here, you can set the size of claims you want. PTOS finds patients who have unbilled charges in the amount range you enter. We recommend running insurance claims weekly, billing by unbilled charges over $250. This means a patient being seen frequently will be billed more often than one with fewer visits per week. We find this has made some impressive improvements in cash flow.

ONLY PATIENTS WHO HAVE NOT BEEN BILLED SINCE -If a patient has been discharged, dropped out of therapy, or just doesn't come in very often, they may not have reached the **AMOUNT RANGE** you are billing. By running a group of claims monthly, filling out this parameter for patients who have not been billed in the last month, you are able to pick up any account that has slipped through the cracks.

INCLUDE PREVIOUSLY BILLED CHARGES -When running insurance claims, normally only charges which have not been previously billed are included. This eliminates duplicate billings.

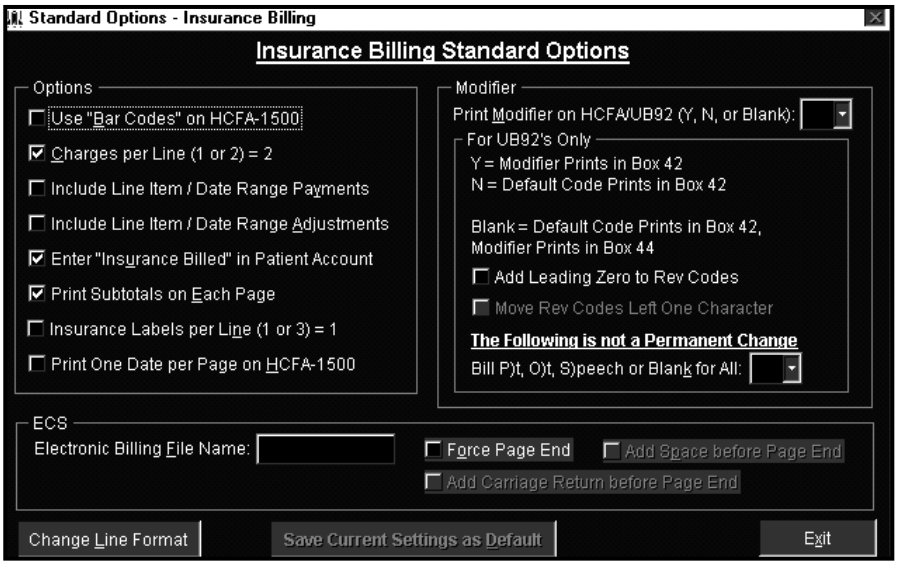
Sometimes you may need to rebill a patient. Perhaps an insurance claim was “lost in the mail” and needs to be resent. Or maybe a payment has been received from the primary insurance and you're ready to bill a secondary carrier.

If you wish to rebill a range of charges for a specific patient, check this box and enter the date range to bill. If you have only a few specific transactions to rebill, you can tell PTOS to rebill these by clicking REBILL while FINDING TRANSACTIONS as explained in the section ENTER OR ADJUST TRANSACTIONS. You may want to rebill a group of patients, for example billing the secondary carrier one month after the primary carrier was billed. This can be accomplished by billing by account type. If you check **INCLUDE PREVIOUSLY BILLED CHARGES**, you will be asked to select **REBILL ALL, UNPAID ONLY, PAID ONLY, THOSE MARKED FOR SECONDARY, OR CHARGES PRIMARY HAS JUST MADE PAYMENT ON.**

These are self explanatory with the exception of the last option**, CHARGES PRIMARY HAS JUST MADE PAYMENT ON.** When posting LINE ITEM or DATE RANGE payments for the primary insurance, you have the option of telling PTOS to bill the remainder to the secondary insurance. If you do so, PTOS will mark the "WHO TO BILL" field with an "X”. You can then select secondary insurance billing and tell PTOS to rebill previously billed charges. You don't need to enter a date range because the system already knows which charges have been marked as having been just paid by the primary insurance.

PTOS will automatically bill ONLY those charges that the primary insurance has just made a payment on regardless of the date range covered by the payment. After billing the charges, "WHO TO BILL" is automatically replaced with an "S".

The above options can vary from one billing run to the next. As with PATIENT BILLING, there are the **“STANDARD”** options that once set, probably won’t change. If you click **STANDARD OPTIONS** from the INSURANCE BILLING screen, the following options can be set:


Standard Options - Insurance Billing
Insurance Billing Standard Options
Options
Use "Bar Codes" on HCFA-1500
Charges per Line (1 or 2) = 2
Include Line Item / Date Range Payments
Include Line Item / Date Range Adjustments
Enter "Insurance Billed" in Patient Account
Print Subtotals on Each Page
Insurance Labels per Line (1 or 3) = 1
Print One Date per Page on HCFA-1500
Modifier
Print Modifier on HCFA/UB92 (Y, N, or Blank):
For UB92's Only
Y = Modifier Prints in Box 42
N = Default Code Prints in Box 42
Blank = Default Code Prints in Box 42, Modifier Prints in Box 44
Add Leading Zero to Rev Codes
Move Rev Codes Left One Character
The Following is not a Permanent Change
Bill P)t, O)t, S)peech or Blank for All:
ECS
Electronic Billing File Name:
Force Page End
Add Space before Page End
Add Carriage Return before Page End
Change Line Format
Save Current Settings as Default
Exit

USE BAR CODES -There are two versions of the HCFA-1500 form. One version has several black bars in the top left corner, the other version does not. The bar code version is not very common, but some insurance may require it. If you don't use the bar code version, PTOS will automatically type the name and address of the insurance carrier in the top left corner, and this is the standard format for the HCFA. If you need the bar code version, you can indicate that here.

This moves the insurance carrier name and address to the far right of the top of the form.

CHARGES PER LINE - In the charge section (box 24), there is room to fit two lines per block. This is acceptable by most insurance, and cuts the number of forms you send in half. Sometimes, an insurance carrier may insist that only one line per block be used. If this box is checked, two charges will print on each line. If it is not checked, only one charge per line will print.

INCLUDE LINE ITEM PAYMENTS/ADJUSTMENTS - If you have used Line Item or Date Range posting (described under "Enter Transactions".), payments (and/or adjustments) can be applied against individual charges. If you are billing a secondary carrier, you can select to have payments (and/or adjustments) already received for the charge included under the "Payments" total on the claim.

ENTER INSURANCE BILLED – You may include an "Insurance has been billed" statement in the patient account. This is a regular DEBIT transaction in a format which states the carrier name, the amount billed and the dates of service billed, for example "Blue Cross billed $650.00 for 09/01/4 thru 09/30/4." This will appear on the patient statement and any transaction lists as a billing reference. It is necessary if you want be able to get BILLING EFFICIENCY or INSURANCE TRACER reports, and is also important for various lists. As with patient statements, you may wish to suppress the "Insurance has been billed" statement if you are rebilling a claim.

PRINT SUBTOTALS- This determines whether to SUBTOTAL ON EACH PAGE of a **LINE ITEM UB92,** or Box 28 of the HCFA-1500 form. If you check this box, page totals are printed in box 28. Otherwise, PTOS will print "CONTINUED ON NEXT PAGE".

INSURANCE LABELS PER LINE – If you have PTOS generate labels, you can select from one across or three across labels.

PRINT ONE DATE PER PAGE – Usually you will want to fill a HCFA-1500 form, printing several days activity on each form. If you want to generate one form for each day, check this box.
ELECTRONIC BILLING FILE NAME - APS supplies interfaces with several major insurance companies, as well as electronic "intermediaries". If you are taking advantage of electronic billing, enter the transfer file name which has been supplied by your ECS intermediary. You may also need to check the box to FORCE PAGE END, ADD SPACE BEFORE PAGE END, or ADD CARRIAGE RETURN depending on the requirements of your ECS intermediary.

PRINT MODIFIER -A modifier of up to six characters can follow the RVS/CPT code printed on either the HCFA-1500 or the UB92. If you want the modifier to print, indicate so here.

The default codes referred to for box 42 of the UB92 are:

1 = 420/421	**3 = 440/441**	**5 = 430/431**
2 = 424	**4 = 444**	**6 = 434**

If the UB92 is the selected form you can indicate if you want to ADD A LEADING ZERO to revenue codes (i.e. "0421" instead of "421").

BILL PT, OT OR SPEECH -This allows each category to be billed separately on the UB92. If you wish, you can bill only PT charges for a patient or group of patients then make a second pass and bill all OT charges for the same patient.

As with PATIENT BILLING, you should start by setting these standard options to meet your needs. You can later modify them permanently, or change them for an individual run of insurance claims.

INSURANCE FORM ALIGNMENT
After the first claim has printed, PTOS will stop and ask if the form is aligned properly. If the alignment is too far off, you may need to SET PRINTER LINE FORMATS as explained previously.

*****NOTE *** When the HCFA-1500 is printed, Box 26 contains the patient account number, account type, and claim number. The claim number is automatically assigned by PTOS and can be used for tracking the claim. Each patient starts with claim "1", the number increasing each time a claim is generated for the patient**.

6. MANAGEMENT REPORTS

Management Reports are available to provide you with practice analysis data. These are all on-demand reports, which means they can be run as often as desired rather than on a preset schedule. The selection of Management Reports is shown below with examples of various reports. You don't need to run every report. Decide which are most applicable to your office and print only those reports. There are two reports you should run every month to verify that your Accounts Receivable are in balance. These are the Accounts Receivable by Account Number and Collection Analysis.

Virtually all reports can be run for a specific OFFICE #, LOCATION, (or revenue center), or for the entire practice as a whole. Some reports ask if you want to include discharged patients. Other reports ask if you want to include categories with no activity for the period, such as referrals or account types with no activity. With most reports, you are asked the time frame to include on the report. You will almost always use the current month, however you may look at data from past months, or totals for a quarter, or even year-to-date, PROVIDING THE DATA FROM THOSE PAST MONTHS HAS NOT BEEN REMOVED.
*****NOTE*** The totals shown on different reports for the same time period may not be equal. PTOS provides a great deal of flexibility so that you can track statistics the way you want. For example, you aren't REQUIRED to enter a treating therapist when you post a payment. If you don't, however, that payment won't be credited to a therapist on the THERAPIST ACTIVITY REPORT, but on other reports that look for total payments, it will be included. It's important to retain your DAILY TRANSACTION REPORTS (described in the section on SYSTEM TASKS), so that if there is a discrepancy, you can find out why.**

The various reports provide productivity and statistical analysis of your practice. Many of the PTOS reports use the same column headings, so we'll explain them here in detail.

NEW -are new patients for the time period. A new patient is one whose DATE FIRST SEEN field in the Patient File is within the time frame of the report.

DISC -The number of patients who were discharged during the report period. For PTOS to know the patient was discharged, you MUST fill out the DISCHARGE DATE in the Patient File.

ONGOING -is the number of ongoing patients - those still being treated. A patient is ongoing if the DISCHARGE DATE has not been entered.

TREAT -is total patients treated during the time period, NOT the number of active patients. For example, if you ran the report for a one week period, and even though some patients hadn't been discharged, they didn't come in for treatment during that week, those patients would not be counted under TREATED.

NOTE The above four groups are NOT meant, and probably won't, balance from one report to the next. For reasons like the one described under TREAT, New patients, plus Ongoing, minus Discharged patients will only sometimes equal Treated patients.

CHARGES -are total charges for the period.

PAID or PAYMENTS -are total payments received for the period. Some reports break out patient (**PAT**) and insurance (**INS**) payments separately.

ADJUSTS -shows NET adjustments (debits less credits) for the time frame of the report. The number would be positive if debits exceed credits, or it can be negative if credits exceed debits. Some reports break out **CREDITS** and **DEBITS** separately to give detailed picture of the adjustments made to accounts.

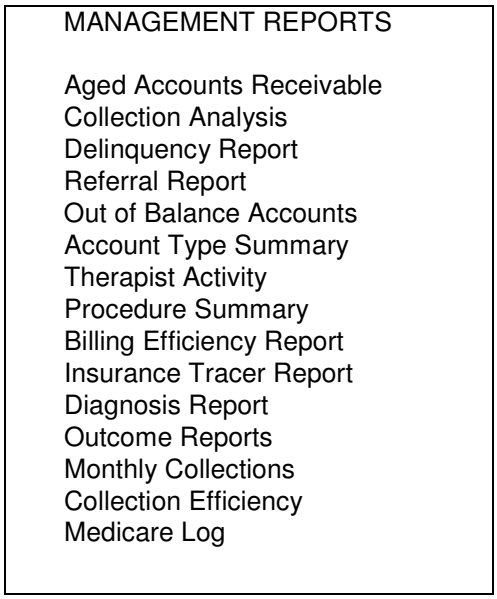
VISITS or VIS -represents the total number of treatments during the period. A visit is a charge transaction, where you have told PTOS that VISIT = Yes.
UNITS -are total treatment units. When you create a PROCEDURE CODE, or post an INDIVIDUAL transaction, PTOS asks for units. The total of these units are printed here.

PCT-This is the PERCENT the previous column represents of the total.

AT or TYP -is the patient's account type. For many reports, report, such as the DELINQUENCY report knowing the type of account can be important.

AVG - is the average of the preceding column, for example, average charges per patient may follow the CHARGES column.

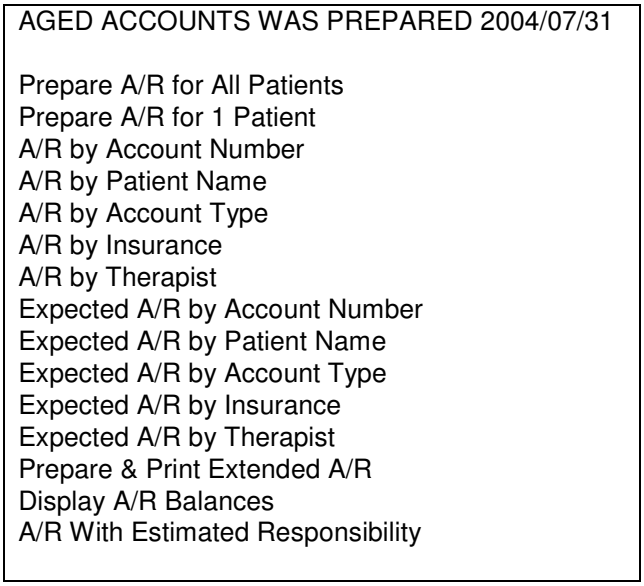
The Daily Transaction Report from the Daily Tasks menu in System Tasks menu MUST be run before any Management Reports. This assures that any newly entered transactions are included in the analysis. Remember, when you REMOVE OLD ACCOUNTS all data for those patients is deleted from the system. Any payments or other activity for those patients will not be included in reports. Therefore, run any reports that should include data for patients to be removed before removing the accounts.



AGED ACCOUNTS RECEIVABLE

A very important report for any practice is the Aged Accounts Receivable Report. It shows what is owed by patient accounts. PTOS gives you several ways of looking at receivables. An example of an Aged Accounts Receivable printout is shown on a following page.

When you post an entry in PTOS, it calculates the account so that your financial data is accurate. Generally, at the end of the month, you'll want to recalculate (prepare) aged accounts so that they are aged to the current month, and print out the receivable report for reference and follow up. When Aged Accounts is selected from the Management Task Bar, the following screen is displayed showing the accounts receivable options, and showing the last time Aged Accounts Receivable was prepared.


AGED ACCOUNTS WAS PREPARED 2004/07/31
Prepare A/R for All Patients
Prepare A/R for 1 Patient
A/R by Account Number
A/R by Patient Name
A/R by Account Type
A/R by Insurance
A/R by Therapist
Expected A/R by Account Number
Expected A/R by Patient Name
Expected A/R by Account Type
Expected A/R by Insurance
Expected A/R by Therapist
Prepare & Print Extended A/R
Display A/R Balances
A/R With Estimated Responsibility

PREPARE A/R FOR ALL PATIENTS
Preparing Aged Accounts should be run before any of the PRINT A/R options. This recalculates all balances. When you select PREPARE A/R, PTOS first tells you the system date it is preparing for. The system date is the date you enter when you first start PTOS. PTOS ages the accounts up to this date. For example, if there was a $50 charge on July 14, 2004, and you, prepared Aged Accounts with a system date of July 30, 2004, the charge will fall in the CURRENT category, since it's less than 30 days old. If you were to Prepare Aged Accounts with a system date of August 15th., the charge would be in the "30 DAYS" category.

NOTE When calculating ACCOUNTS RECEIVABLE, transactions AFTER the SYSTEM DATE are NOT included. If you change the system date to run reports for prior months, you MUST, when finished, re-start PTOS with the current date and again PREPARE AGED ACCOUNTS so that transactions are re-calculated up to the current date.

Keep in mind the affect of Line item or Date range payments and/or adjustments on your Accounts Receivable. One of the advantages of these methods of posting is that the payment or adjustment is applied directly to the proper charge. This means the tracking of amounts owed is VERY accurate. It also means that you cannot re-run Accounts Receivable for a prior time period, because any Line Item or Date Range payments or adjustments that were posted since the old report was originally run, will now be included against the charges they were posted to, probably showing the total A/R to be lower than when it was originally run.

When Preparing A/R, PTOS asks you to "ENTER STARTING DATE FOR REPORTS" and "ENTER ENDING DATE FOR REPORTS". When you Prepare Aged Accounts, the information used in many other Management Reports is also calculated. The STARTING and ENDING dates refer to the date range you want reports compiled for. PTOS will default to preparing for the current month, i.e. STARTING 2004/07/01, ENDING 2004/07/31, but you could change the dates to STARTING 2004/01/01, ENDING 2004/03/31 to get reports for the first quarter, or any other time frame you wish to view.

***NOTE *** When PREPARING ACCOUNTS RECEIVABLE, much of the data used in other Management Reports is calculated. The CHARGES, PAYMENTS, ADJUSTMENTS and VISITS that appear on many other reports are based on the dates you select when A/R is prepared. It's essential to fill in the STARTING and ENDING dates for the period you want to use for ALL reports. When some of the reports are run, PTOS again asks for the date range. This is used to calculate numbers such as NEW, ONGOING, DISCHARGED, and TREATED patients. For your reports to be accurate, make sure the date range you prepare the AGED ACCOUNTS for is the same date range used when the reports are actually printed.

After ACCOUNTS RECEIVABLE has been prepared, any of the Print Accounts Receivable selections can be run. Each patient's account is summarized showing the total balance due and breaking the balance into amounts which are current, 30 days old, 60 days old, 90 days old, and over 120 days.

After all patient data is summarized; totals for the practice are shown. Also included is the PERCENT of the total balance that each aging category represents. The PERCENT figures are very important information in determining collection efficiency and month-to-month improvement. It is expected that the total dollar amounts over 30, 60 days, etc., will vary from month to month, the PERCENT in each category is a much more consistent indicator of collection efficiency.

PREPARE A/R FOR ONE PATIENT
This does not print, but internally ages all transactions for one account, and updates the "Patient

Data File". This could be run if a patient's balance doesn't seem right and you want PTOS to recalculate it.

A/R BY ACCOUNT NUMBER
The report is printed in patient number order, similar to the format shown below.

AGED AIR BY INSURANCE FOR 2004/07/31 ALL LOCATIONS

PATIENT	AT	CURRENT	30-60	60-90	90-120	120+	BALANCE
INSURANCE: AETNA							
120898 Straman, Larry	L	54.00	276.00	102.00	300.00	312.00	1044.00
120909 Delon, John	L	7 8.00	123.00	207.00	384.00	0.00	792.00
120925 Rumph, George	L	108.00	114.00	60.00	0.00	0.00	282.00
120935 Coulter, Fred	1	78.00	306.00	100.00	0.00	0.00	484.00
120936 Hansen, May	S	138.00	215.00	174.00	0.00	0.00	527.00
120080 Bormalham, Mason	L	24.00	180.00	270.00	226.00	892.00	1592.00
120181 Irelan, Harry	L	90.00	360.00	306.00	539.00	1140.00	2435.00
120231 Sullivan, Olive	W	138.00	84.00	12. 00	72.00	258.52	564.52
SUB TOTAL, 8 PATIENT(S)		1050.00	2294.00	2041.00	1773.00	3184.52	10342.52
PERCENTAGE OF SUB TOTAL		10.15	22.18	19.13	17.14	30.76	

A/R BY ACCOUNT TYPE
This prints in the format described above, grouped and summarized by Account Type. If this option is selected, you can specify one account type to print.

A/R BY INSURANCE
This format is shown in the example above. It is grouped and summarized by PRIMARY insurance carrier. If you wish, you can print the report for one specific insurance carrier.

A/R BY THERAPIST
Prints in the same format described above, only grouped and summarized by Assigned Therapist.
NOTE A/R by Account type, Insurance or Therapist can be printed in Summary format if desired. This means that instead of printing a line for each patient, only a one line summary for the Account Type, Insurance Carrier or Therapist will print.

EXPECTED A/R
Expected accounts receivable reports print in the same formats as the above. They are based on the amounts you have designated as "EXPECTED" when you created the PROCEDURE CODE or when you posted the charges. This is very useful in projecting your true cash flow. When these reports are run, any payments received are subtracted from the amount you indicated as expected, the remainder being what you still expect to receive.

PREPARE AND PRINT EXTENDED A/R
This generates a special accounts receivable report. The standard A/R reports age accounts out to 120 days. You may also have VERY old accounts, such as liens, which may go back years. The Extended A/R report allows a detailed breakdown of these accounts.

Extended A/C Recievable Reports
Date Range 1
Date Range 2
Date Range 3
Date Range 4
Enter Location For Report(Blank For All)
Enter Office For Report(Blank For All)
Enter A/C Type(Blank For All)

When this option is selected, you are asked for the aging categories you want to see. In the example below, we've requested 120, 150, 180 and 210 days. This then finds all accounts with a balance over 120 days, and groups the balance in amounts which are between 120 and 150 days, 150 to 180 days, 180 to 210 days, and anything over 210 days. Since you select the aging categories, you can break down the report any way you want. Since ANY time frames can be specified, you may want to see very new accounts, such as 0 to 15 days, 15 -30 days and so on. You can also run the report for just one account type if you wish.

DISPLAY ACCOUNTS RECEIVABLE BALANCE

This calculates and displays your up-to-the-minute receivable totals. It can be run if you want to see totals without printing any reports. You can also specify one office or location to total.

A/R WITH ESTIMATED RESPONSIBILITY

The following is a sample Estimated Responsibility Report. Based on information you've supplied, such as patient deductible, percent to bill patient and co-pay amounts, PTOS calculates the portion of each account's balance that is due from the patient and what is due from insurance. Keep in mind that this is an estimate only, of what is due from patient and insurance.

ESTIMATED RESPONSIBILITY A/R REPORT

AT	PT	PATIENT	PAT#	CURENT	30-60	60-90	90-120	120+	INSRSP	PATRSP	TOTAL
L	GM	Straman, Lar	120898	54	276	102	300	312	744	300	1044
L	GM	Delon, John	120909	78	123	207	384	0	442	350	792
L	KK	Rumph, Georg	120925	108	114	60	0	0	172	110	282
1	GG	Coulter, Fre	120934	78	306	100	0	0	304	180	484
S	SR	Hansen, May	120936	138	215	174	0	0	527	0	527
L	GM	Bormalham	120080	24	180	270	226	892	1002	590	1592
L	GM	Irelan, Harr	120181	90	360	306	539	1140	1435	1000	2435
W	SR	Sullivan, O.	120231	138	84	12	72	258	564	0	564
W	SR	Simer, Bill	120355	144	258	402	84	240	1000	128	1128
TOTAL				1050	2294	204	1773	3184	7124	2288	10342

COLLECTION ANALYSIS

Collection Analysis is another report which is best run on the last day of each month. This report shows all charges, insurance and patient payments, debit, and credit adjustments, visits, and units for each day of the month, or other time periods you've selected and totals each category. If you wish, you can include a second line for each day which will show the expected amount and total payments received. TOTALS print at the bottom of the page as well as Net Change in

accounts receivable (charges plus debits for the month, less payments and credits) for the period included, along with average visits per day and average charge per visit. This is the second management report that is used to balance "MONTH END ACTIVITY"

COLLECTION ANALYSIS FOR 07/10/04 - 07/10/04 PRINTED 07/10/04 ALL LOCATIONS

DATE	CHARGES	INS PAID	PAT PAID	DEBITS	CREDITS	VISITS	UNITS
04/10/01	92.50	0.00	0.00	0.00	0.00	2.00	7.00
04/10/02	376.50	40.00	0.00	0.00	25.10	5.00	16.25
04/10/03	286.00	30.00	20.00	0.00	85.00	6.00	18.25
04/10/04	200.00	0.00	0.00	0.00	0.00	3.00	8.50
04/10/08	132.00	0.00	0.00	0.00	8.80	3.00	7.50
04/10/09	157.00	360.00	0.00	0.00	0.00	5.00	15.25
04/10/10	92.50	0.00	0.00	0.00	0.00	2.00	6.75
TOTALS	2197.00	420.00	20.00	0.00	118.90	26.00	79.50
NET CHANGE	1645.00	WORKING DAYS 7	AVG VISITS/DAY 3.7		AVG CHARGE/VISIT		84.50

DELINQUENCY REPORT

When the delinquency report shown on the next page is printed, you can select accounts with balances over 30, 60, 90 or 120 days. You can also only print accounts with no recent payments to find the truly delinquent accounts.

This report uses 2 or 3 lines for each patient. The first line shows patient number and name, aging category totals, total balance due and the last date a payment was received. The second line shows the patients account type, phone number for reference, and the total payments made on the account. There is also a large blank space to enter a collection note. If you are entering collection notes in the NOTES LINE 2 field of the Patient Screen, you can elect to include these as line three of the patient's listing on this report.

PTOS asks if you want to print for only one account type, and whether to sort by patient number or by account type so that all patients within an account type can be grouped together. If sorting by account type is selected, patients within each account type will be sorted by BALANCE.

DELINQUENCY REPORT FOR ACCOUNTS OVER 90 DAYS AND NO PAYMENT SINCE 05/01/04

PAT#	NAME	Balance	120+	90-120	60-90	30-60	CURRENT	PAID
00005	Craft, William	2209.00	1084.00	593.00	532.00	0.00	0.00	04/04/11
	M 453-0944							2112.00
00009	Foreman, Bob	1433.60	1433.60	0.00	0.00	0.00	0.00	
	M 390-0922							
00021	Renkie, James	566.00	0.00	0.00	420.00	146.00	0.00	04/03/21
	M 221-0923							
00042	Terpich, Martin	582.00	0.00	188.00	320.00	70.00	4.00	04/02/21
	P 213/239-0933							
00044	Pepe, Brian	494.00	94.00	200.00	90.00	70.00	40.00	04/04/12
	P 390-6373							453.34
00050	Bliver, Samuel	378.00	378.00	0.00	0.00	0.00	0.00	
	P 390-2293							
00058	Wenne, Susan	228.00	228.00	0.00	0.00	0.00	0.00	
	W 213/0392							
00060	Wimpell, Sherry	1851.00	0.00	1523.00	230.00	98.00	0.00	04/01/24
	W 213/341-0012							880.00
0072	Sermon, Diane	1600.00	0.00	1054.00	546.00	0.00	0.00	04/03/19
	W 220-0113							
00088	Gead, Nicholas	1502.00	0.00	0.00	232.00	270.00	1000.00	
	W 339-1187							
Totals		32894.30	7871.60	5233.70	11157.00	7029.00	1603.00	

REFERRAL REPORT

When the Referral Report option is selected, there are two formats from which to choose. The Monthly Referral Report asks if you want Primary Doctor, Referring Doctor or Attorney. The report then lists all physicians or attorneys who have referred patients, with a summary of activity represented by each referral including the last date a new patient was referred. This report is valuable in analyzing which doctors are sending profitable referrals. Running the report on a monthly basis provides an accurate gauge of increasing or decreasing activity of various physicians.

NOTE Since this report uses the entries you place in the REFFERAL SOURCE or** ATTORNEY fields in the patient file, the referral or attorney may print more then once on the report IF YOU HAVE SPELLED THEIR NAME DIFFERENTLY for different patients.

```
REFERRING DR. REFERRALS FOR 2004/07/01 -2004/07/31 PRINTED 04/07/31          LOCATION 0
REFERRAL SOURCE      NEW  DISC  TREAT  PCT  CHARGES    PCT  VISITS   PAID  LAST REF
CARLSON, BILL, MD      1     0     15  27.3  4114.00  26.09     65   100.00  04/06/30
DEBBANS, JOSEPH, MD    6     1     11  20.0  2138.00  13.56     45   234.40  04/07/22
DRAKE, ERNEST, MD      2     1      1   1.8   390.00   2.47     10    70.00  04/07/02
MARTIN, RONALD, MD     1     0     14  25.5   186.00  32.89     61  1020.00  04/07/04
JAMES, JOHN, DDS       4     0      3   5.5  1138.00   7.22     31   234.10  04/05/21
JAMES, WILLIAM, M.D.   1     2      6  10.9  2132.00  13.52     33  2301.00  04/06/20
JOHNSON, ED, M.D.      5     1      1   1.8   108.00    .70     12    20.00  04/07/13
STEVENS, JOHN, D.D.S.  3     0      4   7.3   560.00   3.55     48   134.00  04/07/02
TOTALS                23     5     55       15766.00          305  12457.20
```

The second Referral Report format is a Year-To-Date summary, an example of which is shown on the following page. You define the months to show under CHANGE PARAMETERS in SYSTEM TASKS. PTOS then calculates the charges, visits and new referrals for each month of the year. In order to fit all 12 months on one line, cents are dropped from monthly charges, only the dollar amount is shown.

```
REFFERALS YEAR-TO-DATE FOR 2004 PRINTED 04/10/31
FIRST LINE = CHARGES (DOLLARS), SECOND LINE = REFERRALS, THIRD LINE = VISITS
  04/01   04/02  04/03  04/04  04/05  04/06  04/07  04/08  04/09  04/10  04/11 04/12
   1244    3412   2231   3451   2672   4312   3313   1123   7612   4231
REF   3       5     12      3      7      9     11      5     12      9
VIS  21      62     42     70     47     79     60     30    120     83
CULLMAN, JOHN, M.D.       TOTAL CHARGES   39120   REFERRALS  93   VISITS  603

    944   1112   5331   2431   2655   3112   5383   2423   5611   3131
REF   5      6     10      6      7     11     15      9     18     11
VIS  14     20    115     70     67     69    150     70    114     63
DENNISON, NEIL, M.D.    TOTAL CHARGES   27810   REFERRALS 113   VISITS  533
```

NOTE A doctor MUST be in the REFERRAL FILE to be included in this report.

OUT OF BALANCE REPORTS

If you are posting payments or credits using the Date Range or Line Item method, and entries are deleted incorrectly or a data file is damaged, it is possible for the account to become out of balance. This results if the amounts paid or credited to each charge do not match the corresponding debit that PTOS creates during posting. Running this report lists any accounts which are out of balance, showing whether patient or insurance payments, or credits are out of balance and by how much. You can then list transactions for the patient to see where the error has occurred.

ACCOUNT TYPE SUMMARY

This provides an analysis by account type similar in content to the Referral report. You can select Monthly or Year-To-Date report formats.

ACCOUNT TYPE SUMMARY FOR 04/07/01 - 04/07/31 PRINTED 04/10/31 LOCATION 1

AT	PAID	NEW	ONGOING	DISC	TREAT	PCT	CHARGES	PCT	VISITS	PCT
C	2340.00	9	31	3	11	12.4	3132.00	10.31	43	11.81
L1	5640.00	3	21	4	15	16.9	2941.00	9.68	38	10.44
MC	2259.20	8	24	2	23	25.8	4420.00	14.56	45	12.36
P1	1859.20	6	14	7	13	14.6	8420.00	27.72	95	26.10
WC	8198.00	7	48	4	27	30.3	11458.00	37.73	143	39.29
TOTAL	20296.40	33	138	20	89		30371.00		364	

THERAPIST ACTIVITY REPORT

As with the previous two reports, Therapist Activity can be run in a monthly or year-to-date format. The monthly report is useful in measuring the productivity of therapists. The statistics can be used to assign patient loads, calculate bonuses, and analyze treatment trends. It is important to keep in mind that the data shown on the MONTHLY report is calculated from the patient file. This means it is a summary of PATIENTS ASSIGNED TO THE THERAPIST. Charges, payments and visits are totaled for patients assigned to each therapist. If a therapist other than the assigned therapist treated a patient, it is still calculated into the assigned therapists totals. To see charges, visits and payments by treating therapist, you must use the YEAR-TO-DATE REPORT.

*****NOTE *** A therapist MUST be assigned to at least one patient, that is, have their code entered as assigned THERAPIST in the Patient File. If the therapist doesn't appear at least once in the Patient File, they won't be included on this report, even if their code was used in posting transactions**.

THERAPIST ACTIVITY REPORT FOR 04/10/01 - 04/10/31 ALL LOCATIONS

THERAPIST	PAID	NEW	DISC	TREAT	PCT	CHARGES	PCT	VISITS	PCT	$/VIS
GM GEORGE MO	9783.90	34	13	98	55.4	11274.00	45.30	318	57.9	35.45
JJ JAMES JELLISON	10221.50	14	10	79	44.6	13605.00	54.68	231	42.1	58.90
TOTALS	20005.40	48	23	177		24879.00		549		47.44

The Therapist Year-To-Date Report, shown below, looks the same as the Referral report, with the addition of a fourth PAID line for each therapist. The PAID line shows total payments for each month of the year. These four lines are totaled for each therapist and an additional amount, **"TOT PD"** is printed. The TOT PD amount is a total of all payments in the system credited to the therapist, even if the payments were not made in the year being printed. The CHANGE in TOT PD from one report to the next indicates the total payments credited to the therapist during the period between reports. This TOT PD amount looks at the treating therapist, rather than the assigned therapist as described in the monthly report above. If you want to see total payments made against charges generated by a therapist, this is the report to look at.

To appear on this report, the therapist does not have to have any patients assigned in the Patient file. The therapist must, however, be entered in the THERAPIST File.

```
THERAPIST YEAR-TO=DATE FOR 2004  PRINTED 04/10/31
 1ST LINE = CHARGES/2ND LINE =  NEW PATIENTS/3RD LINE = VISTITS/4TH LINE = PAID
  04/01  04/02  04/03  04/04   04/05  04/06  04/07  04/08  04/09  04/10  04/11 04/12
  28244  27412  29231  29451   29972  29812  28913  29523  28512  29231
NEW  23     35     32     23      27     39     31     25     22     39
VIS 221    262    242    270     227    279    260    230    220    283
  21244  23412  24231  27451   25672  24312  23313  21123  27612  24231
GEORGE MOORE    TOTAL CHARGES  391201  NEW PATS 331  VIS 3403  PD 212231

  23944  25112  23331  22331   22655  23112  22383   24423  26611  23131
NEW  25     22     30     26      27     31     25      39     28     31
VIS 214    220    215    270     267    269    250     270    214    263
  21244  23412  22231  23451   22672  24312  23313   21123  27612  24231
JAMES JELLISON  TOTAL CHARGES  327810  NEW PATS 321   VIS  3533 PD 301982
```

*****NOTE*** If you REMOVE INACTIVE ACCOUNTS you MUST rerun PREPARE AGED ACCOUNTS, and re-print the YEAR-TO-DATE THERAPIST ACTIVITY REPORT to calculate the total payments in the system after the removal. This gives you a new baseline, so that the next time the YEAR-TO-DATE report is run, the difference between two reports will represent total charges and total payments received in the period.**

PROCEDURE SUMMARY REPORT

When you update PROCEDURE CODES, you tell PTOS the fee for a procedure, and if you want, the time it takes, and cost to the practice to perform the treatment. The PROCEDURE SUMMARY will then total the number of times each procedure was used during the period, the charges billed for each procedure code and **"I"** (individual) codes. You also have the option of choosing to include "I" codes ONLY. If you choose "I" codes only, all "I" codes (individually entered charges) are sorted and subtotaled by DESCRIPTION. The report can be grouped by THERAPIST, ACCOUNT TYPE or LOCATION.

You may run the report for a specific insurance or diagnosis code. This breaks down procedures posted for patients covered by that insurance, or with the selected primary diagnosis code.

The report will show what was collected for transactions that contain the code, and by subtracting COST from COLLECTED, PTOS is able to calculate PROFIT and PROFIT MARGIN (%).

PROCEDURE CODE		BILLED	COLLECTED	%	#DONE	TIME	COST	PROFIT	%
AE	Aerobic Exercise	1168.00	985.00	84	23	522	689.00	296.00	30
EMG	EMG Biofeedback	768.00	522.84	68	32	388	503.00	19.84	4
CB	Contrast Bath	496.00	412.86	83	24	201	350.00	62.86	15
GT	Gait Training	260.00	171.78	66	10	93	130.00	41.78	24
HP	Hot Packs	240.00	237.14	01	18	189	156.00	81.14	34
ICE	Ice	1050.00	931.23	89	21	775	649.00	282.23	30
MS	Massage	580.00	545.35	94	14	449	309.00	236.35	43
MB	Mobilization	780.00	770.59	01	27	602	467.00	303.59	39
PAR	Paraffin	120.00	103.57	86	14	201	70.00	33.57	32
PHNP	Phonophoresis	108.00	93.21	86	5	72	67.00	52.21	56
RM	Range of Motion	612.00	540.36	88	31	475	340.00	200.36	37
ST	Strength Testing	572.00	542.14	95	16	448	300.00	270.14	50
TR	Traction	695.00	664.34	96	20	523	380.00	284.34	43
US	Ultrasound	390.00	382.68	98	33	224	240.00	232.68	61
WP	Whirlpool	560.00	390.78	70	18	301	302.00	88.78	23
TOTALS		9641.00	8204.04		345	6369	5671.00	3891.00	

Collection and profit information can only be computed if LINE ITEM or DATE RANGE posting is used to enter payments. This way PTOS knows what was paid for each procedure. Remember, payments for a charge may not come in for several weeks. So collection and profit amounts for the CURRENT month will probably be understated. You may want to run this report twice; once to get a report of what was billed for the current month and a second report for two or three months prior, which would show what was billed, collected, and the profit from past billing. You can select the Procedure Summary report for "Zero" balance charges only. This means the charge has either been completely paid or adjusted off, so that the report calculations can accurately reflect what has been collected on each procedure.

BILLING EFFICIENCY REPORT

When you run patient and insurance billing PTOS will enter a "PATIENT (or INSURANCE) HAS BEEN BILLED" entry into the patient account. You can then generate a BILLING EFFICIENCY REPORT. This will show every claim or statement that was sent during the period you specify. Also shown is the total number of bills sent, the total amount billed, and the smallest, largest and average size of a bill. We recommend the ideal size of an insurance claim to be $200 to $250. So you may want to try different billing options to achieve this goal.

```
INSURANCE BILLING EFFICIENCY REPORT FOR 04/10/01 - 04/10/31   PRINTED 04/10/31
DATE      PAT #   DESCRIPTION                                        AMOUNT CLAIM

04/10/15  000003  Aetna Life Ins billed 1144.00 for 10/01-10/09/1  1144.00   4
04/10/15  000007  Great West     billed  154.00 for 10/01-10/09/1   154.00   7
04/10/15  000011  General Americ billed  196.00 for 10/01-10/05/1   196.00   3
04/10/15  000017  Henry Ford Hos billed  240.70 for 10/01-10/09/1   240.70   1
04/10/20  000058  Aetna Life Ins billed  428.00 for 10/04-10/12/1   428.00   15
04/10/20  000062  BC/BS of NY    billed  150.00 for 10/08-10/12/1   150.00   2
04/10/27  000066  Business Men's billed  144.00 for 10/08-10/22/1   144.00   5
04/10/30  000092  Henry Ford Hos billed   26.00 for 10/13-10/23/1    26.00   6
04/10/31  000106  Warner Life    billed  269.00 for 10/27-10/28/1   269.00   10
04/10/31  000112  Creative Risk  billed  132.00 for 10/08-10/12/1   132.00   9
04/10/31  000116  A&P            billed   67.00 for 10/10-10/12/1    67.00   23
04/10/31  000120  Aetna Life Ins billed   58.00 for 10/09-10/15/1    58.00   13
04/10/31  000060  Warner Life    billed 1321.00 for 10/11-10/15/1  1321.00   44
** TOTALS  14 CLAIMS     8,973.70 AMOUNT BILLED    358.95 AVERAGE PER BILL
                 16.00 SMALLEST AMOUNT BILLED   1321.00 LARGEST AMOUNT BILLED
```

INSURANCE TRACER REPORT

After sending an insurance claim, you should keep track of whether or not it has been paid. If you can spot an unpaid claim in a few weeks rather than a few months, it will make a big difference in accounts receivable and collection efficiency.

First, enter the date range to print. All open insurance claims that were generated during this period will be listed. This means they have had no payments posted to the claim. The CLAIM NUMBER is included, as a reference to be used when posting insurance payments. For this list to be accurate, when you do insurance billing, you MUST tell PTOS to enter an **"INSURANCE HAS BEEN BILLED"** entry into the patient account, and you must enter the claim number being paid when posting insurance payments. Sometimes a claim may be sent, but there are no payments on the claim since it applies to the patient deductible. To prevent that claim from appearing on this report, you can mark it as having been applied to the patient's deductible. This option is available by using FIND to pull up the "INSURANCE HAS BEEN BILLED" entry and marking it as applying to the deductible.

```
INSURANCE TRACER REPORT   04/08/15 THRU 04/08/31 LOCATION S
DATE      PATIENT                    DESCRIPTION

04/08/19  S0021  Flanders, Alice  American Gener billed 166.00 for 07/19-07/21/4  3
04/08/19  S0026  Waxler, Nancy    Aetna Life Ins billed 260.00 for 07/19-07/29/4  1
04/08/19  S0032  Clark, Alan      Blue Cross Ins billed 168.00 for 07/19-07/31/4  4
04/08/22  S0040  Erwing, Lance    Aetna Life Ins billed 172.00 for 07/22-07/28/4  6
04/08/22  S0044  Prescow, Bob     AAA Insurance  billed 294.00 for 07/22-07/31/4  1
04/08/25  S0058  Young, Paul      Williams & Lee billed 328.00 for 07/25-07/31/4  1
04/08/25  S0062  Winston, Karen   BC/BS of NY    billed 250.00 for 07/25-07/29/4  2

TOTALS  OPEN CLAIMS 11      2,572.70 TOTAL AMOUNT        233.88 AVERAGE PER BILL
```

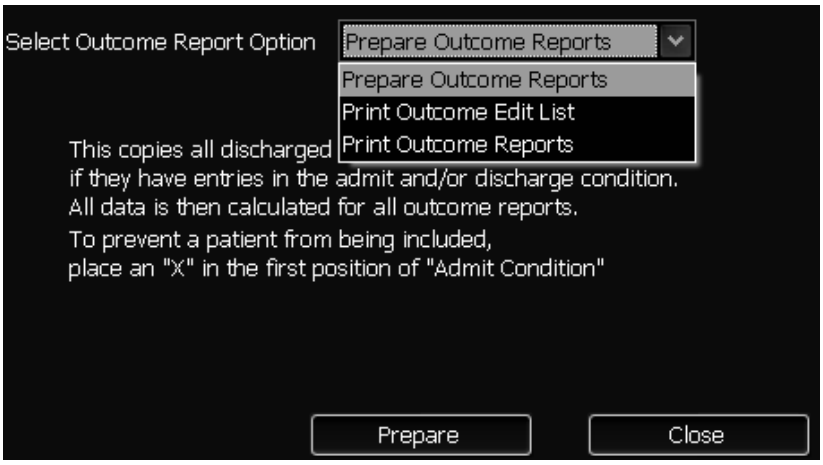
DIAGNOSIS REPORT

This report prints in two different formats depending on whether you select all patients of DISCHARGED PATIENTS ONLY. If you select only discharged, the format on the following page is used. This looks only at discharged patients with a “ZERO” balance on their account. Since the account has been closed (the patient is discharged and the balanced has been either paid or adjusted off), more extensive reimbursement data is available. Each diagnosis or injury area is summarized, showing average DAYS from first visit to discharge, how many patients are in the category, and the total and average of CHARGES, VISITS and PAYMENTS received for each diagnosis. PTOS also includes the average charge per visit ($/VIS) and average paid (PD/VIS).

DIAGNOSIS REPORT FOR 04/01/2006 - 04/30/2006 PRINTED 20061103
FOR ALL OFFICES PAGE NUMBER 1

DIAGNOSIS	NEW	DISC	TREAT	PCT	CHARGES	PCT	VIS	PCT	$/VIS
715.16	1	0	1	2.2	430.00	1.17	2	0.90	215.00
715.90	0	0	1	2.2	1835.00	5.00	12	5.42	152.91
715.96	0	0	1	2.2	350.00	0.95	2	0.90	175.00
719.41	1	0	2	4.5	1680.00	4.58	9	4.07	186.66
719.47	1	0	1	2.2	1840.00	5.02	8	3.61	230.00
720.2	0	0	1	2.2	365.00	0.99	4	1.81	91.25
721.0	1	0	2	4.5	1195.00	3.26	6	2.71	199.16
722.10	0	0	1	2.2	460.00	1.25	4	1.81	115.00
722.52	1	0	1	2.2	1665.00	4.54	9	4.07	185.00
722.80	0	0	1	2.2	1400.00	3.82	5	2.26	280.00
722.83	0	0	1	2.2	705.00	1.92	4	1.81	176.25
723.1	0	0	3	6.8	3285.00	8.96	22	9.95	149.31
723.4	1	0	1	2.2	345.00	0.94	2	0.90	172.50
724.2	3	0	8	18.1	4817.59	13.14	30	13.57	160.58
724.4	3	0	4	9.0	2195.00	5.99	13	5.88	168.84
726.0	0	0	1	2.2	975.00	2.66	5	2.26	195.00
726.10	0	0	1	2.2	1160.00	3.16	8	3.61	145.00
728.85	0	0	1	2.2	790.00	2.15	6	2.71	131.66
805.4	1	0	1	2.2	1430.00	3.90	12	5.42	119.16
TOTALS	13	0	33		23764.59		163		165.78

OUTCOME REPORTS


Select Outcome Report Option
Prepare Outcome Reports
Prepare Outcome Reports
Print Outcome Edit List
Print Outcome Reports
This copies all discharged
if they have entries in the admit and/or discharge condition.
All data is then calculated for all outcome reports.
To prevent a patient from being included,
place an "X" in the first position of "Admit Condition"
Prepare
Close

Outcome Reports provide important management data. When you select this option, the following menu appears. You must first select “Prepare Outcome Reports” option. This compiles outcome data for all discharged patients. It is similar to Prepare Aged Accounts. It only needs to be run once for each batch of reports you may select. After the data has been prepared, it will remain unchanged and available for any Outcome Report options until you again run the option, at the end of the following month, for example.

The information portrayed on your Outcome Reports will only be valid if you have entered data accurately into the system. It is especially important that ADMIT COND and DISCHARGE COND levels have been entered consistently. Also, date of injury, first visit and discharge must be correct. To help verify accuracy of data, “Print Outcome Edit List” option of the above menu prints an edit list showing key data for each discharged patient. You should print and audit this list before printing any of the Outcome Reports. You may want to exclude some patients from the outcome reports. If you place an “X” in the first position of ADMIT CONDITION in the patient's file, their data will not be included in outcome reports. After running Prepare Outcome Reports and Print Outcome Edit List options you're ready to start printing reports. There is a wide range of report formats available. When you select “Print Outcome Report” option, the menu below will appear. You can select the formatting of data to be included on the Outcome Reports, and run this option as many times as you desire to see the outcome data presented in different ways.

The first question is the date range in which the patient was discharged. Only patients discharged between the Start and End date will be included. You can select to run this list by a specific Location, Office or Account Type. Next you are asked to choose a SORT category. Primary Diagnosis or Injury Area are the most common, but you can also sort and compare outcomes based on the insurance carrier, account type, or any of the several other sort groupings. Sorting by insurance carrier, for example, may show differences in outcome based on the number of visits the carrier will authorize.

A third major category is "GROUP BY". The Outcome Reports are multi-dimensional. Not only do they show outcomes by diagnosis or injury area, they compare how those outcomes vary by other factors, such as how soon the patient was treated after their injury.

ENTER GROUPS

GROUP	DAYS BETWEEN INJURY AND FIRST VISIT ARE:
1	LESS THAN
2	GREATER THAN GROUP 1 AND LESS THAN
3	GREATER THAN GROUP 2 AND LESS THAN
4	GREATER THAN GROUP 3 AND LESS THAN
5	GREATER THAN GROUP 4

There are five date range groupings that can be specified. In the above case, you may enter “15” as the first group, “30" in the second, “45” in the third and "60” in the fourth. This means you want to *see* the outcome compared based on how soon you saw the patient after they were injured. A sample is shown in the report below.

Instead of grouping by INJURY TO FIRST VISIT, you may want to see how outcome varies based on the duration of treatment, so choose 1ST VISIT TO DISCHARGE. An ENTER GROUPS screen similar to the one above would appear, only you would enter five date ranges that represent the duration of treatment. Any of the seven possible GROUPINGS can be selected and their corresponding date range groups entered.

In the sample report, admit and discharge levels are being compared only in two categories. You don't need to enter levels and compare all six categories. You may only be interested in one or two comparisons, such as overall functional level in category one, and pain in category two. PTOS permits you the flexibility of specifying what each category represents, and how many categories you wish to compare.

DIAGNOSIS OUTCOME REPORT FOR 04/10/01 - 04/10/31 PRINTED 04/10/31

	AVERAGE CHANGE BY CATEGORY						AVERAGE		TOTAL
INJURY - 1ST VISIT	1	2	3	4	5	6	CHARGE	VIS	DAYS	PATS
354.00										
LESS THAN 15 DAYS	6.2	4.8	0.0	0.0	0.0	0.0	964	12.1	32.0	3
15 - 29	5.0	4.1	0.0	0.0	0.0	0.0	1097	14.2	33.2	3
30 - 44	5.2	4.0	0.0	0.0	0.0	0.0	1498	16.2	35.4	6
45 - 59	5.1	3.7	0.0	0.0	0.0	0.0	1134	16.8	37.0	4
MORE THAN 59	4.2	3.2	0.0	0.0	0.0	0.0	1239	17.9	41.2	2
GROUP AVERAGE	5.5	3.7	0.0	0.0	0.0	0.0	1298	15.8	39.4	18
717.81										
LESS THAN 15 DAYS	5.9	5.4	0.0	0.0	0.0	0.0	1503	15.1	37.8	4
15 - 29	5.6	5.0	0.0	0.0	0.0	0.0	1553	16.3	39.1	4
30 - 44	4.5	4.4	0.0	0.0	0.0	0.0	1652	16.8	42.2	3
45 - 59	4.0	4.2	0.0	0.0	0.0	0.0	1765	17.3	46.3	6
MORE THAN 59	4.2	3.8	0.0	0.0	0.0	0.0	1910	18.1	51.0	7

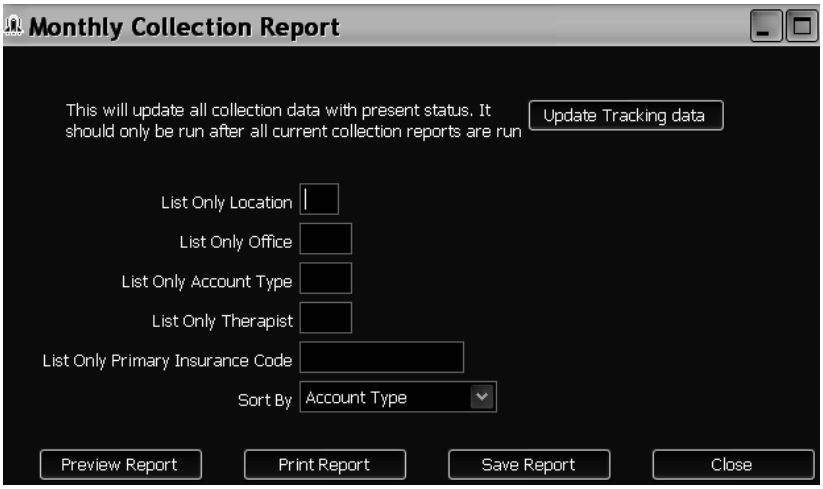
One format that some practices choose for category 6, is the result of a patient questionnaire. Nothing is entered in category 6 under ADMIT COND. After the patient is discharged, they rate their satisfaction with therapy. This score is entered in category 6 of DISCHARGE COND. You now have a comparison of patient satisfaction, which can be sorted by therapist, account type or other criteria. It can also be compared with your evaluation of the outcome in the other five categories. Another recommendation is to use a category to indicate results of a follow-up after 6 months or one, year. You can develop a scoring system to measure things like degree of to normal activity and out of work days due to a recurrence of the same problem. If you can show a doctor, insurance carrier or contract payor that your rehabilitation is significant in the long term,

you have a solid marketing tool.

The numbers in each category show THE AVERAGE DIFFERENCE IN VALUE FROM ADMIT TO DISCHARGE. In the above example, you see that for patients whose primary diagnosis is 354.00, the GROUP AVERAGE INCREASE in functional level (as this is what you assigned category one to mean) is 5.5. You further see that if the patient is seen sooner, for example with 15 days of injury, you get a higher increase in functional level, in this case 5.9. At the far right are average charges, average visits,and average duration of treatment (in days), for patients in the group. Total patients in the group is also shown.

There is a tremendous amount of information available through the many possible Outcome Report formats. Experiment with different combinations until you find a mix of reports that are the most useful for your individual requirements.

MONTHLY COLLECTON REPORT
Each month payments are received. These are for charges that may be from two weeks ago, or two months ago. Knowing the age of charges that are being paid helps manage collection activity. This report shows what payments were received in the various Accounts Receivable aging categories. In order for the report to be accurate, payments must be posted using the LINE ITEM or DATE RANGE format. When you select this option, the screen below appears.


Monthly Collection Report
This will update all collection data with present status. It should only be run after all current collection reports are run
Update Tracking data
List Only Location
List Only Office
List Only Account Type
List Only Therapist
List Only Primary Insurance Code
Sort By
Account Type
Preview Report
Print Report
Save Report
Close

To initiate collection tracking for the first time, you must start by selecting option 2, to Update Tracking Data. This sets a baseline against which payments for the next period will be measured. Once you run option 2, all new payments will be tracked in their appropriate aging categories. At the end of the tracking period, let's say one month later, you can select option 1 to print the MONTHLY COLLECTION REPORT. A report that looks like an Aged Accounts Receivable Report will be printed, however the amounts shown under CURRENT, 30-60, etc., will be totals of payments that were received for charges in those periods. After printing Monthly Collection Reports in any of the formats that you require, again select option 2, to Update Tracking Data. This sets a new baseline to measure collections for the next period. Whenever you run option 2, a new baseline set. Only payments posted after this will be in the next Monthly Collection Report.

MONTHLY COLLECTIONS REPORT PRINTED 04/10/31 ALL LOCATIONS

PATIENT	AT	CURRENT	30-60	60-90	90-120	120+	PT
120898 Straman, Larry	L	0.00	70.00	100.00	300.00	0.00	AR
120909 Delon, John	L	0.00	100.00	200.00	90.00	0.00	AR
120936 Hansen, May	S	138.00	215.00	0.00	0.00	0.00	GM
120181 Irelan, Harry	L	0.00	60.00	60.00	150.00	1100.00	GM
120231 Sullivan, Olive	W	50.00	0.00	12.00	78.00	218.50	BC
GRAND TOTALS		188.00	445.00	372.00	618.00	1318.50	

COLLECTION EFFICIENCY REPORT

This report show TOTAL charges in the time frame you request. It also shows the amount of UNPAID charges, those with no insurance payments, and PAID charges, those that have had an insurance payment posted. The total insurance payments, patient payments and adjustments are included along with the balance still outstanding for these charges. The most important information on this report is the last column, AVERAGE DAYS. This shows the average number of days from the time a charge is posted until the first INSURANCE payment is received.

COLLECTION EFFICIENCY REPORT FOR 10/01/2004 - 10/31/2004 PRINTED 10/31/2004

INS CODE	TOTAL CHARGES	UNPAID CHARGES	PAID CHARGES	INSURE PAID	PAT PAID	ADJUSTS	PD CHRG BALANCE	AVG DAYS
AARP	75.00	75.00	0.00	0.00	0.00	0.00	0.00	
BLSH	105.00	70.00	35.00	35.00	0.00	0.00	0.00	23
BLUE	200.00	0.00	200.00	140.00	50.00	10.00	0.00	25
DWP	70.00	20.00	50.00	0.00	20.00	5.00	25.00	
MCAR	175.00	75.00	100.00	50.00	20.00	10.00	20.00	21
GRAND TOTALS	625.00	240.00	385.00	225.00	90.00	25.00	45.00	23

MEDICARE LOG

This report is designed as a summary of activity for Rehabilitation Agencies. It contains a great deal of information and therefore prints on two pages, as shown on the next page. The last column on the first page and the first column on the second page show the patient number. By aligning these columns, you in effect have a double wide report.

The first page contains patient name, date range of treatment, primary insurance ID (HIC#), patient birthdate, primary insurance code and last date the insurance was billed for the date range being printed. Total charges are shown along with a 20% and 80% standard Medicare breakdown.

The second page breaks down total PT, OT, Speech and OTHER charges and visits. Proper coding must be used as explained in UPDATE PROCEDURE CODES for Rehab Agencies. Total insurance and patient payments, and credits for these charges are included.

MEDICARE LOG REPORT FOR 2004/07/01 - 2004/07/31 PRINTED 04/07/31

NAME	DATE RANGE	HIC #	BIRTH	INS	BILL	TOTAL	20%	80%	PAT #
Roberts, Bob	0515-07089	554672234	122120			780.50	156.10	624.40	1001AR
Aaron, Robert	0621-07089	176549895	100423	MEDI	07084	1109.00	221.80	887.20	1003RO
Abbott, Phil	0610-07129	172543199	011918	MEDI	07264	1498.00	299.60	1198.40	1014OP
Abrams Gerry	0702-07089	186288944	121515	MEDI	07064	461.00	92.20	368.80	1101AU
Adams, Rich	0720-07209	207501763	052619	MEDI	07264	1502.50	300.50	1202.00	1144MR
Agliis, Kent	0628-07139	192529044	050101	BC01	07284	618.00	123.60	494.40	1913KE

TOTALS: NUMBER OF PATIENTS 10 8078.00 1615.60 6462.40

PAGE 2 **********

PAT #	PTCHARG/VIS		OTCHARG/VIS		SPCHARG/VIS		OTHER	INSPAID	PATPD	CREDIT
1001AR	780.50	12	0.00	0	0.00	0	0.00	80.00	0.00	7.00
1003RO	103.00	1	0.00	0	0.00	0	0.00	0.00	0.00	0.00
1014OP	796.00	10	0.00	0	0.00	0	0.00	0.00	0.00	0.00
1101AU	1109.00	18	0.00	0	0.00	0	0.00	130.00	0.00	0.00
1144MR	1318.00	27	45.00	2	135.00	6	0.00	172.74	0.00	201.26
1913KE	428.50	12	0.00	0	384.00	1	0.00	571.20	0.00	0.00

TOTAL PTCHARGES	PTVIS	OTCHARGES	OTVIS	SPCHARGES	SPVIS	OTHER
6307.50	109	848.50	9	922.00	16	0.00

TOTAL INSPAID	PATPAID	CREDIT
1795.28	0.00	245.26

7. PATIENT LISTS

Patient Lists provide the administrative staff with information needed to conduct day-to-day business. Patient Lists are divided into three types; Treatment lists, Financial lists and Demographic lists. The Patient Lists menu is shown below.

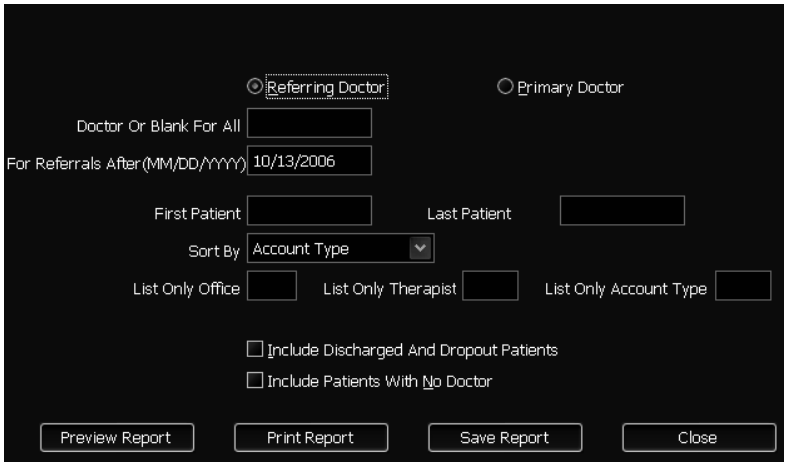
PATIENT TREATMENT LISTS	FINANCIAL LISTS	DEMOGRAPHIC LISTS
By Doctor	Patient Number	Name
Return To Doctor	Account Type	City
Diagnosis	Primary Insurance	Zip Code
Injury Area	Secondary Insurance	Birthdate
Therapist	Social Security Number	Employer
Injury Date	Payor	Employer City
First Visit	Attorney	Occupation
Last Visit	Notes	Cover Sheet
Remaining Visits	Zero or Small Balance Accts	Sort
Authorization Date	Credit Balance Accounts	
Discharged	Pre-Billing Edit	
Dropout	Co-Pay Accounts	
No Activity	Patients At Charge Limit	
Payment Plan/Deductible	Balance Calculated on Expected Amount	
HIPAA Dates		

TREATMENT LISTS

BY DOCTOR

When you select a list, there are several questions PTOS asks to let you specify exactly who you

want included and how you want the data sorted and totaled. Much of this is the same regardless of which list you select. If you select **PATIENTS BY DOCTOR**, the following screen appears:



Many of the above parameters appear on each of the PATIENT LIST options. These parameters allow you to specify a range of patient account numbers. You can also select one office, one therapist, or one account type. ***NOTE*** **"If you enter only the first character of account type, all account types that start With that character will print.**

Some parameters vary from list to list. In this example, you select whether to list the referring or primary care doctor, the default being referring doctor. You can also ask for one specific doctor, such as listing only patients referred by Dr. Smith. PTOS also asks if you want only doctors who referred patients after a certain date, allowing you to suppress inactive doctors. The SORT BY field appears on most lists. This is a "sub-sort". This list will print sorted by doctor, but since there are probably many patients for each doctor, these will be grouped by your sub-sort criteria.

The final question is to include patients who have no doctor entered. Instead of lengthy explanations of each list, only the highlights of are described below. To see a sample printout, look at the PATIENT NUMBER LIST later in this section. After you've entered some patients into the system, printout samples of all lists. This will help you determine which lists to use regularly.

RETURN TO DOCTOR
This is a listing of patients who have a return date to see their referring physician entered in the Patient Data File. PTOS first asks the date range to print. You may select to print patients who will be returning this week, within the next month, or all patients who have a return date scheduled. You can also elect to sort the list by doctor, therapist, return date or patient name. This report is useful in allowing the therapist to schedule treatment programs and progress reports. Remaining visits are also shown, to reflect how many authorized treatments the patient has remaining.

DIAGNOSIS
PTOS asks if you want only primary diagnosis or all diagnoses. You can choose whether to print the ICD9 code or descriptive diagnosis. The list can be run for all diagnoses or a specific description. Selecting PRIMARY DIAGNOSIS, is more meaningful, and much faster. The list is sorted by diagnosis, and you can choose sorting within each diagnosis by therapist, account type, primary insurance, doctor or employer. If you sort by employer, the last column on the list will be employer. If you sort by insurance, the last column will be insurance code. All other selections will print the referring doctor.

INJURY AREA
Listing by injury area is similar to diagnosis, but is grouped by a broad category such as neck, back, arm, instead of specific diagnosis. The columns printed, and secondary sort criteria are the same as the diagnosis list.

THERAPIST
Patients are grouped by assigned therapist. The therapist's code, patient number and name are listed, along with the patient's home and work phone, account type and diagnosis, and referring doctor, employer or insurance, depending on the sort criteria you select.

INJURY DATE
This lists all patients whose injury date is in a date range you specify. This can be sorted by account type, therapist or doctor. The printout includes therapist, injury, first and last visit dates, and referring doctor.

FIRST VISIT
This list is similar to INJURY DATE above, except it looks at first visit date instead of injury date, and prints TOTAL VISITS instead of INJURY DATE.

LAST VISIT
This is the same as FIRST VISIT, except it looks at last visit date.

REMAINING VISITS
You can specify a REMAINING VISITS number. All patients who have fewer than this number of visits remaining on their treatment plan will print. Included are columns for therapist, first visit, last visit, total visits, account type, authorization date, authorized visits and remaining visits.

AUTHORIZATION DATE
Any patients whose authorization date is within the date range you specify will print, using the same format as REMAINING VISITS above.

DIACHARGE
All patients who have been discharged (and have not yet been archived or transferred to Inactive Accounts) are listed. Included is the assigned therapist, discharge date and discharge information, account type and referring doctor.

DROPOUT
All patients who have dropped out (and have not yet been REMOVED from the system) are listed. A dropout is designated by filling in the year and month the patient dropped out, followed by “00’, in the ‘Discharge Date” field of the Patient Data File. For example ‘04/07/00” is a July 2004 dropout. Included are the same columns of information printed on the DISCHARGE List above, except first and last visit dates are substituted for discharge information.

NO ACTIVITY
In a busy office, a patient can sometimes **”fall through the cracks”** and become inactive without being noticed. The sooner you identify someone who is missing treatments, the better your chance of getting them back. The list shows patients who have not been treated during a date range (but have not been discharged or marked as dropouts).

PAYMENT/ PLAN DEDUCTIBLE
When this option is selected, you have the choice of printing either of two lists. All patients who have a deductible to be met can be listed, or all patients who have had a Payment Plan amount entered in their Patient Data screen.

HIPAA DATES
There are two HIPAA dates tracked by PTOS. When this list option is selected, you can choose whether to print HIPAA AUTHORIZATION dates or PRIVACY NOTIFICATION dates. You can

enter a date and PTOS will list all patients whose HIPPA Authorization has or is about to expire, or list all patients who have not received your privacy policies.

FINANCIAL LISTS

NUMBER ORDER

This list prints all patients and can be sorted by Patient Number or Last Name. The total charges, payments and adjustments for the account are included. The last date an insurance claim or patient statement was sent is also shown. This lets you easily spot a patient who has not been billed, or someone with a large outstanding balance. This is the third printout used, along with Aged Accounts by Patient Number and the Collection Analysis Report, to balance your system at month end. The "E" in the far right column shows the EDIT code, and is included on several financial lists.

PATIENT NUMBER LIST PRINTED 2004/07/31

O#	PATIENT	CHARGES	PAID	ADJUST	BALANCE	INS BILL	PAT BILL	E
1	000895 Prido, Felisa	652.00	259.20	0.00	392.80	04/06/31		
1	000909 Delin, Sally	792.00	0.00	0.00	792.00	04/07/12		
1	000920 Morby, Philip	804.00	0.00	0.00	804.00	04/06/31		
1	000936 Hinsen, Darlene	527.00	0.00	0.00	527.00	04/07/13		
1	000028 Olives, Hilda	1832.00	0.00	0.00	1876.00	04/07/11	04/07/08	
1	000181 Ireean, Jennifer	2435.00	0.00	0.00	2435.00	04/07/02	04/06/21	
1	000256 Sundberg, Sarah	1231.00	0.00	0.00	1231.00		04/06/16	
1	000257 Bimer, Debra	1128.00	0.00	0.00	1128.00	04/07/02		
1	000271 Iorham, James	1468.00	0.00	0.00	1468.00		04/07/04	
1	000290 Sedrick, Sara	606.00	209.74	-100.00	452.26	04/06/18	04/03/13	
1	000293 Menninger, Donna	398.00	0.00	0.00	398.00	04/07/02		
1	000295 Christoffer, Jane	381.00	0.00	-165.48	381.00		04/02/14	
TOTALS		21072.00	468.94	-265.48	10174.67			

ACCOUNT TYPE

Patients are sorted and subtotaled by account type. Charges, payments, adjustments and patient, insurance and total balances due are shown.

PRIMARY OR SECONDARY INSURANCE

All patients will be listed sorted by their insurance carrier. You can select the list for Primary insurance or Secondary insurance, and can select only patients covered by a specific carrier be printed. The patient's group number and ID number are included on the list.

SOCIAL SECURITY NUMBER

This list, sorted by Social Security Number, shows the patient's social security number, account type, primary and secondary insurance codes, balance due, and the last time the patient or insurance was billed.

PAYOR

This is a reference for groups of patients with the same payor. Included are payor, account type, patient and total balance due, and the last date the patient statement was sent. You can select a specific payor, or print all patients grouped by their payor.

ATTORNEY

You can select a specific attorney or print all patients grouped by their attorney. The fields used in PAYOR list above are included, except attorney is substituted for payor.

NOTES
As explained under ENTER OR CHANGE PATIENT DATA, different types of notes can be entered into the system. NOTES LINE 1 and 2 are the most significant, since they are displayed on the Patient Data Screen.

When this task is chosen, PTOS asks whether NOTES LINE 1 or NOTES LINE 2 are to be printed. As stated above, NOTES 1 and 2 should be dedicated to a specific purpose, such as treatment authorization in line 1 and collection notes in line 2.This way, if you want a list of collection notes, select NOTES LINE 2. Only accounts with an entry in NOTES LINE 2 will print, showing anyone with missing chart data.

When you select this task, PTOS asks if you want to list only entries with a specific description. Let's say that when you make collection calls, you put an entry in Notes line 2 that say the week a payment is due. You can then list notes with the description **"CHECK DUE 7/10/04",** you'll get a list of everyone who should have made a payment that week.

SMALL BALANCE ACCOUNTS
All patients with a balance due less than an amount you enter will be printed. This is a reference of accounts that may need to be adjusted off or Removed from the active files.

CREDIT BALANCE ACCOUNTS
This list prints all patients who have a credit, or negative balance showing for their account. Credit balances could result from overpayments, posting an entry to the wrong account, or adjusting off an amount that shouldn't be adjusted off.

PRE-BILLING EDIT
There is certain "key" information that is needed on most insurance claims. By running the Pre-Billing Edit list, several key fields are checked. Any patients with insurance who are missing the Referring Doctor or the doctor's UPIN number, Diagnosis, Patient Sex, Primary Insurance ID#, or Birthdate are listed. The Pre-Billing Edit report now has the option to exclude patient accounts with a zero balance.

CO-PAY ACCOUNTS
This lists all patients where "CO-PAY" has been marked "YES" in the patient account.

PATIENTS AT CHARGE LIMIT
If you entered a Charge Limit for a patient, you can print this list to show who is at or near their limit. When the list is run, you are asked for a dollar amount, and anyone with a Charge Limit entered and who is within this range will be printed.

BALANCE CALCULATED ON EXPECTED AMOUNT
On the second Patient Data screen, you're able to indicate any accounts whose balance should be calculated on the Expected amount of charges, rather than the amount actually billed. This option allows you to list all such accounts.

DEMOGRAPHIC LISTS

NAME
This can be used as a reference of patient information and as a cross reference for finding the account number of a specific patient. Patients are listed in alphabetical order, with their assigned therapist, account type, home and work phone and an EDIT column. The edit shows an "A" if the patient is to be removed from PTOS when REMOVE OLD ACCOUNTS is run.

CITY
Patients are sorted and subtotaled by the city in the patient's address.

ZIP CODE
Patients are sorted and subtotaled by the sip code in the patient's address.

BIRTHDATE
You can list all patients, sorted by birthdate, or you can select a specific a specific birth month to list.

EMPLOYER
Patients are sorted and subtotaled by employer .

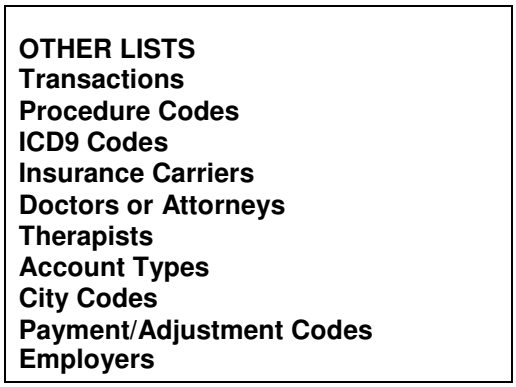
EMPLOYER CITY
Patients are sorted and subtotaled by the city in the employer's address.

OCCUPATION
This sorts patients by their occupation.
COVER SHEET PRINTOUT
This list provides a "cover sheet" which contains the data you've entered on the Patient Data Screens. This can be printed and placed in the patient's file.

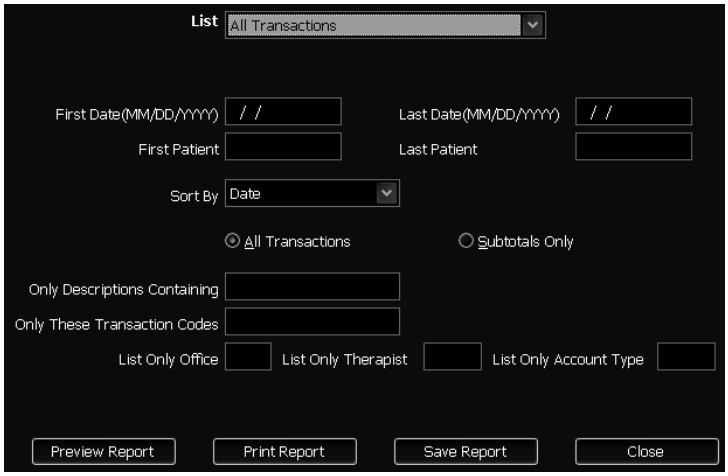
PATIENTS BY SORT
The SORT field in the Patient Data file can contain any miscellaneous information you wish to track for the account. This list sorts and prints any accounts with an entry in the SORT field.

8. OTHER LISTS

As with **"PATIENT LISTS",** these are designed to provide information to the front and back office staff. All lists are described below, with examples of some printouts. When **"OTHER LISTS"** is selected, the menu below appears.



TRANSACTION LISTS
This allows you to list transactions using different parameters. The lists can be used to verify that charges and payments were posted properly. It can also be used as a list of activity by therapist, or to show all charges for a certain account type, such as all Medicare treatments for a month. Some practices use the list as a bill to a nursing home, or other contract type situation. When you select this task, the following menu appears:



First specify the type of transaction list (All Transactions, All Charges, Unbilled Charges, Unpaid Charges, Appealed or Denied Charges, Payments, Adjustments, Chare/Payment For Primary Insurance, Transaction Without Valid Account Number and Reprint A Daily Transaction Report) then fill out any desired parameters. Any of the Transaction Lists allow you to specify a range of dates and patients to include. You can also indicate whether to sort by date, patient, transaction code, account type or therapist or you can sort by the first ten characters of description. All transactions can be listed in detail, or YOU can print just the summary for the dates, patients, etc. that you've selected.

If you enter a DESCRIPTION, only transactions that include the description will print. You can also select one office, therapist, or account type. If you enter only the first character of account type, all account types that start with that character will print.

By filling out the parameters above in different ways, you can get many types of audit lists. If you want to see all entries for one patient, fill in the FIRST and LAST PATIENT with the same account number and leave everything else blank. If you want to see only one location, such as location “A”, the FIRST and LAST PATIENT numbers should be 'A through “AZZZZZ”. By using five zeros and five Z's following the location letter “A”, all patients for location “A” will print. To list transactions for one day only, use the same date for both first and last date.

ALL TRANSACTIONS

If you select option 1, all transactions (charges, payments and adjustments) will print in a format shown below. Any confusion about which transactions were posted on a certain date or range of dates can be resolved with this audit listing.

If you select to sort the list by DATE (the default), all transactions are grouped in date order (similar to the DAILY TRANSACTION REPORT), and subtotals for each date are included. If you sort by patient, all entries for a patient are grouped together (similar to the PATIENT STATEMENT), and subtotaled by patient. You may also sort by therapist, transaction code or account type, in which case all transactions are grouped and subtotaled accordingly. Sorting by the first ten characters of description is very useful in grouping all transactions of a similar type together, such as all "Blue Cross" payments or all "Courtesy Write-offs".

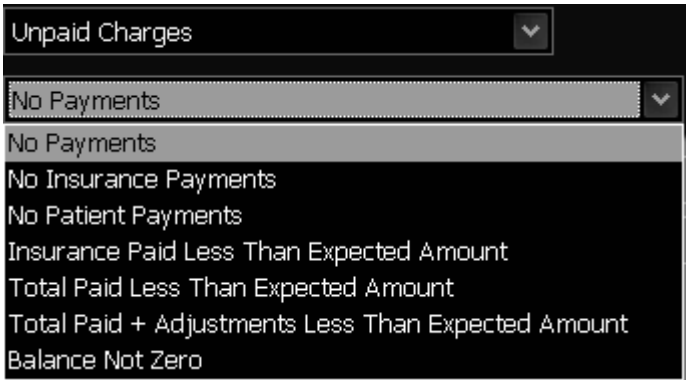
```
TRANSACTIONS FOR  04/11/01 FOR  PATIENT  100000 THRU 1ZZZZZ     PRINTED 04/11/03
DATE     PATIENT                    CODE   DESCRIPTION           AMOUNT  PT   AT  V

04/11/01 1001AR Alex Roberts        97128  Ultrasound             20.00  AR   M   Y
04/11/01 1003PS Pam Simmons         97118  Electrical Stim        32.00  AR   M   Y
04/11/01 1004KL Kent Langenforth    90020  Comprehensive Exam    122.50  AR   B   Y
04/11/01 100621 Alan Clark          P-LIN  BC pd.$366.00 for 10/03-10/01/04   K
04/11/01 100426 Alice Betnae        S-LIN  Alice pd.$360.00 for10/11-10/15/04 A
04/11/01 1004KL Kent Langenforth    97210  Therapeutic Ex         49.00  AR   B   N
04/11/01 1004KL Kent Langenfrouth   99070  Cervical Collar        35.00  AR   B   N
04/11/01 1013PT Pat Telen           97012  Traction, Mech.        40.00  AR   W   Y
04/11/01 1016HP Harriet Powers      97118  Electrical Stim        32.00  AR   M   Y

TOTALS FOR 04/11/01   330.50 CHARGES      5 VISITS     PAID  726.00
```

ALL CHARGES
This looks similar to the list above, but only charges are included.

UNBILLED CHARGES
When you select this option, the following screen option will appear:

Remember from ENTER OR ADJUST TRANSACTIONS that you can enter “P" in WHO TO BILL telling PTOS that this particular charge is to be billed only on the patient statement, not on an insurance claim. Checking Exclude Charges Marked To Be Billed Only will omit those charges marked with a “P”. This can be a useful list in spotting any patients who have **“fallen through the cracks”** and have not been billed.

UNPAID CHARGES
The following list only functions properly if you post payments using DATE RANGE or LINE ITEM posting. This is the only way PTOS can know what has been paid against a specific charge. You can select several criteria to specify which charges to list:



First option lists charges with no payments of any kind.
Second option lists charges with no insurance payments.
Third option lists charges that the patient has not paid on.
Fourth option lists charges where the INSURANCE PAID is less than the EXPECTED AMOUNT.
Fifth option lists charges where patient and insurance payments are less than expected amount.
Sixth option includes charges where patient and insurance payments AND adjustments may

have been made, but the total is still less than the expected amount.
Seventh option includes charges where patient and insurance payments and adjustments may been made, but the total is still less than the TOTAL AMOUNT (not expected amount) of charge.

PAYMENTS
Payments can also be printed for reference. When this option is selected, the screen on the following menu appears.

You can specify insurance, patient, or both types of payments. By filling out DESCRIPTION to list on the first TRANSACTION LIST screen, you can generate a list of all payments from a certain insurance carrier. For example, to list Blue Cross payments for July, enter 05/07/01 through 05/07/31 as the dates to list from and through, and “Blue Cross" as the description to list. A sample list of PAYMENTS BY DATE is shown below. The designation P-LIN and S-LIN indicate that these payments were posted as either Date range or Line-item payments.

You can also be even more specific and enter a four digit INSURANCE CODE. If you have several different Blue Cross plans and only want to list payments for one specific plan, enter the INSURANCE CODE for that plan.

```
PAYMENTS FOR 04/11/01
DATE     PATIENT             CODE   DESCRIPTION                                AMOUNT PT  AT

04/11/01 100203 Art Liffe    P-LIN  Benson pd.$144.00 for 10/01-10/05/04    144.00  A  MC
04/11/01 100507 Gary Winston P-LIN  Aetna pd.$1154.00 for 10/01-10/09/04   1154.00  A  MM
04/11/01 100017 Bob Prescow  P-LIN  Benson pd.$640.70 for 10/01-10/09/04    640.70  A  MC
04/11/01 100621 Alan Clark   P-LIN  Alan pd.$366.00 for 10/03-10/01/04      366.00  K  MM
04/11/01 100426 Alice Betnae S-LIN  Alice pd.$360.00 for 10/11-10/15/04     360.00  A  MM
04/11/01 104032 Barry Cross  P-LIN  Gen Ins pd.$569.00 for 10/08-10/15/04   569.00  B  P1
04/11/01 102240 Nancy Waxler P-LIN  Benson pd.$168.00 for 10/06-10/09/04    168.00  A  MC
04/11/01 100044 Ines Tisura  P-LIN  Aetna pd.$94.00 for 10/08-10/15/04       94.00  B  P1
TOTAL     PATIENT PAID 726.00  INSURANCE PAID 2965.70      TOTAL 3191.70
```

ADJUSTMENTS
This is a similar reference list to the PAYMENTS list described above. You can select the specific type of adjustments from the following menu.

CHARGES AND PAYMENTS FOR PRIMARY INSURANCE
This is a special printout that lists charges and payments grouped and subtotaled by the patient's primary insurance. For this list to print properly, you must indicate P or S (for primary or secondary insurance payment), when you post payments. If you neglected to enter the P or S on all payments, this list can still be utilized. When PTOS prints the total charges, payments and adjustments for an insurance carrier, it prints two totals for payments and two for adjustments. INS PD (MARKED P) totals all payments that were marked “P” indicating they were made by the primary. INS PD (TOTAL) includes all insurance payments. The same criteria are used for printing WRITE-OFF (MARKED P) and WRITE-OFF (TOTAL).

TRANSACTIONS WITHOUT VALID ACCOUNT NUMBER
In rare instances, you may accidentally delete a patient account. Periodically running this list will show any transactions that do not have a corresponding patient account. If the transactions are invalid or were made in error, you also have the option to automatically delete them.

REPRINT A DAILY TRANSACTION REPORT
You should keep all DAILY TRANSACTION REPORT printouts as permanent audit lists. If you need to reprint a missing report, select this option and enter the number of the report to be reprinted.

APPEALED OR DENIED CHARGES
Charges that you have marked as appealed or denied can be listed through this option.

PROCEDURE LISTS
When you need to generate reference lists of procedure codes or procedure detail codes, there are several options. The following menu appears when this option is chosen.

First option lists only the Procedure Code and Statement Description Line as a quick reference.
Second option shows all fields of procedure information, just as you see it on the ENTER PROCEDURE CODES screen.
Third option lists the procedure code and the last date it was used. This is helpful when purging old, unused procedure codes.

ICD9 CODES

With this option, you are able to print a list of all diagnosis codes. You can list only codes with a specific diagnosis, such as any codes containing "LUMBAR", or you can generate a list of all codes as a reference. You can also select if you want the list sorted by ICD9 CODE, DESCRIPTIVE DIAGNOSIS, or INJURY AREA.

INSURANCE CARRIERS
When this task is selected, you are asked whether you wish to print the list in order of INSURANCE CODE or INSURANCE NAME. As with other lists, you can print only carriers with a specific NAME, or for all codes. A description "Blue", for example, would call up **"Blue Cross -**

Van Nuys., "Blue Cross of California", "Blue Nose Insurance", and any other carriers with the word BLUE in their name. You can also print a "short" list with only names and codes instead of all insurance carrier information.
Whenever new carriers are added or information about carriers changes, this list can be printed. All name and address data is shown for each insurance company. It is also used as a reference to the operator when entering insurance codes in the Enter or Change Patient Data task.

DOCTORS AND ATTORNEYS
You can list all doctors or attorneys in the Referral File, sorted by Code, Specialty, Last Name or Print Name. You can also ask for only doctors or attorneys with a specific name, such as all Dr. Smiths. All fields in the Referral File are printed for reference.

THERAPISTS
This list shows all therapists in the system, sorted by either Name or Therapist Code.

ACCOUNT TYPES
The Account Type list can sort by Account Type Code, or Account Type Name. You can print just a quick reference list containing just the code and name, or a detailed list showing all fields for each account type.

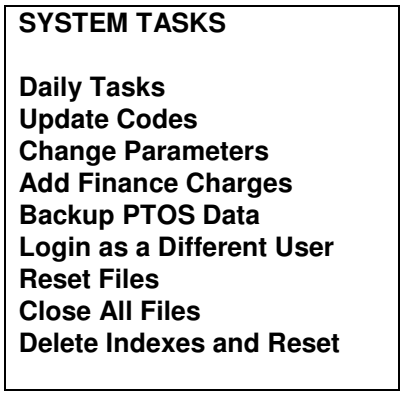
CITY CODES
This shows all City Codes you've entered, sorted by City Name, City Code, or Zip Code.

PAYMENT/ADJUSTMENT CODES
Similar to Procedure Codes, Payment/Adjustment Codes make posting payments and adjustments quicker and more consistent. This listing shows the codes you've created and can be printed in code or description order.

EMPLOYERS
This lists all employers in the system.

9. SYSTEM TASKS

System Tasks are **"housekeeping"** operations used to personalize PTOS for the individual practice and maintain and update system operations. The System Tasks menu is shown below.



DAILY TASKS
After posting new transactions you'll need to run options from the DAILY TASKS menu. When you select this option, the menu shown below appears. Although called "DAILY" tasks, you don't have to run them once per day. Sometimes you may enter several day's entries, and then run

one DAILY TRANSACTION REPORT. Other times, if you enter a lot of transactions in one day, you may want to run several lists during the day.

DAILY TASKS

1 = View on Screen
2 = Print Bank Deposit Slip
3 = Print New and Deleted Transactions

3 - PRINT NEW AND DELETED TRANSACTIONS

We'll start with option 3 first because it's the most important. When transactions are first posted, PTOS marks them as new. You can then print an audit list to verify accuracy. Selecting option 3, **"Print New and Deleted Transactions"** from the DAILY TASKS menu will enable these new entries to be printed on the audit list, which is called the DAILY TRANSACTION REPORT. Once they have been printed,they are no longer considered new. If you later want a list of all transactions for a given day, just go into OTHER LISTS and select TRANSACTION lists. When you select "Print New andDeleted Transactions", the following menu appears.

PRINT NEW AND DELETED TRANSACTIONS
1 = PRINT DAILY TRANSACTION REPORT
2 = Sort by Therapist
3 = Sort by Data Entry ID

PRINT DAILY TRANSACTION REPORT

The most important of these options is PRINT DAILY TRANSACTION REPORT. This is your KEY audit list if you ever have questions of what was posted into PTOS. When you run this list, ALL new and deleted transactions will print, for all offices and all locations. The "ENTER LOCATION" and "ENTER OFFICE" parameters are not functional. If you have the APS Accounting Module, and have instructed PTOS to automatically update your General Ledger accounts, the updating will take place as Print New and Deleted Transactions is run. See the ACCOUNTING MODULE SUPPLEMENT for an explanation of how accounts are updated. The automatic updating of General Ledger is set in the **"CHANGE PARAMETERS"** option of SYSTEM TASKS. The following is a sample DAILY TRANSACTION REPORT. Before you "Print **New and Deleted"** entries, there are several other options you can select.

DAILY TRANSACTION REPORT FOR 07/01/2005 REPORT #746

PAT#	NAME	CODE	DESCRIPTION	AMOUNT	PT	POS	V	ID
05/06/30								
V1001	***DELETED***	97128	Ultrasound	20.00	JT	11	Y	CB
05/07/01								
V1021	Alex Roberts	97128	Ultrasound	20.00	JT	11	Y	CB
V1003	Pam Simmons	97118	Electrical Stimulatio	32.00	AR	11	Y	RA
V1004	Kent LangenForth	95833	Comprehensive Exam	122.50	JT	11	Y	RA
V1004	Kent LangenForth	97110	Therapeutic Exercise	45.00	JT	11	N	RA
V1004	Kent LangenForth	99070	Cervical Collar	35.00	AR	11	N	RA
V1013	Pat Telen	97012	Traction, Mechanical	40.00	AR	11	Y	CB

TOTALS 370.00 CHARGES 250.50 PAID 0.00 ADJUSTMENTS 5 VISITS

PRINT TRANSACTIONS SORTED BY THERAPIST
This prints a list similar to the DAILY TRANSACTION REPORT, sorted and subtitled by the treating therapist.

PRINT TRANSACTIONS SORTED BY DATA ENTRY ID
This prints a list similar to the DAILY TRANSACTION REPORT, sorted and subtotaled by the two ID code of the PTOS user who entered the transaction. As explained in CHANGE PARAMETERS, each user should be assigned a five character password (which may be shared by several users) and a unique two digit ID code. When you start PTOS and enter this seven character USER ID. PTOS tracks it and prints the two digit ID code on NEW AND DELETED TRANSACTION lists.

OTHER DAILY TASKS OPTIONS

1- VIEW ON SCREEN
Instead of printing, you can "View on Screen" to see what will be printed. If you spot an incorrect entry, you can go into ENTER OR ADJUST TRANSACTIONS and delete it BEFORE running the DAILY TRANSACTION REPORT. If an entry is deleted BEFORE it's printed on the audit list, it never becomes part of the patient's permanent record, and therefore isn't included as a deleted entry on the report. This just gives you a "cleaner" audit list. When viewing the list you can show new transactions only, deletions only, or both new and deleted. You can also sort the list by account number or the actual order they were entered into PTOS.

2- BANK DEPOSIT SLIP
If you wish, PTOS can automatically print a bank deposit slip. Since PTOS will only include NEW payments on this slip, it MUST be run before the DAILY TRANSACTION REPORT is printed. **ONLY NEW PAYMENTS (THOSE WHICH HAVE NOT PRINTED ON THE DAILY TRANSACTION REPORT) ARE INCLUDED, AND ONLY THOSE PAYMENTS WITH AN ENTRY IN THE "BANK #" FIELD.** This field should contain the bank number for checks, and may contain the entry **"CASH"** for a cash payment, if you want cash included on the deposit slip. When the slip is printed, you have the option of subtotaling by check. If one insurance check was applied to several patients, you'll probably want it subtotaled. You can also select that CASH be subtotaled, again, this is the preferred option.

UPDATE CODES
This subject is covered in the first section of this manual.

CHANGE PARAMETERS
This is covered in the first section of the manual

ADD FINANCE CHARGES
If you desire, finance charges can be added to overdue balances. This can help motivate patients to pay their bills in a timely manner. PTOS allows you to select who should be billed finance charges, and the interest rate to bill. Before adding the charge, "Aged Accounts Receivable Report" can be run so the overdue balances are aged exactly, to the day.

You may want to add a finance charge to lien cases or cash accounts but not charge interest to Medicare or Worker's Comp patients. When you select this task, the following menu appears.

ADD FINANCE CHARGES

ENTER ACCOUNT TYPES TO CHARGE

ENTER DESCRIPTION FINANCE CHARGE
ENTER PERCENT TO CHARGE
ENTER A MINIMUM FINANCE CHARGE AMOUNT
CHARGE ACCOUNTS OVER 3)0, 6)0, 9)0 OR 1)20 OVERDUE
CHARGE A)LL OR D)ISCHARGE PATIENTS ONLY

PTOS asks for the account types you want charged, as. well as a description. In some states, you can't charge a **"Finance Charge",** but you could charge a **"Rebilling Fee**". So PTOS lets you put in the description you want. The standard finance charge is 1.5% but you can modify the percent as needed. If you want a minimum charge, such as $5.00, that can be entered, and you can select the definition of an overdue account. The default is billing the charge to an account 90 days past due, but you can change this to over 30, 60, or 120 days. You can also indicate to only charge a finance charge to patients who have been discharged.

Finance charges are entered as DEBITS by PTOS. This means they will appear as a charge on patient statements and in financial calculations but will not be billed on insurance claims. Only add interest charges to an account type once a month. If you run this task for the same account type more than once in a given month, an additional charge will be posted to the account.

BACKUP PTOS DATA

This option copies PTOS data to a separate folder on your computer. **THIS DOES NOT TAKE THE PLACE OF BACKING UP YOUR PTOS DATA ON ZIP DISKS OR OTHER MEDIA AND TAKING IT OFFSITE FOR ADDED SAFETY.**

LOGIN AS A DIFFERENT USER

This lets you change the system date or your password level without having to exit and restart PTOS.

RESET FILES

You should never turn off your computer while it is running a task. If you do, you may damage data files. If data becomes scrambled due to **"abnormal ends",** or hardware malfunctions, RESET FILES can frequently recover files into usable condition. YOU SHOULD **RUN RESET FILES ONCE PER WEEK** just as a maintenance procedure to reorganize into their most efficient format.

CLOSE ALL FILES

This MUST be selected by workstations on a network when RESET FILES or PREPARE ACCOUNTS RECEIVABLE are run. It closes data files so that EXCLUSIVE operations can be run.

DELETE INDEXES AND RESET

This is a more advanced version of RESET FILES that will further defragment data. It can be run if the system slows down do to heavy use, or if there has been a hardware malfunction.

10. SPECIAL TASKS

These are special functions which contribute to the flexibility of the system. When you select this task, the following menu appears:

SPECIAL TASKS MENU:

SEND LETTERS
Send Letters allows you to interface PTOS with a stand-alone word processing program. Most word processing systems will work with PTOS, but any modifications will be your responsibility. You can also print labels using various options.

To SEND LETTERS, first type a standard letter, evaluation, or other report format using your word processing program. These documents must be set up in a **"merge print"** format, so that data from PTOS can be merged into the letter or report. Setting up a document in this manner will be described in a Merge Print section of the word processing manual. Sample merge letters are found on the following pages. Once the merge document has been prepared, select criteria to determine who will get the letter. The menu of Send Letters options is shown on the next page.

PTOS will find the appropriate patients to receive a letter based on which of the options you've selected, and copy the required patient data in a usable format to a **"Merge Print"** file called **"PTOSLETR.TXT". Some letter and label selections should not be sent to patients whose HIPAA Authorization date has passed. PTOS lets you automatically suppress these.**

SEND LETTERS

1 = Delinquent Accounts
2 = Diagnosis OR Injury Area
3 = Doctors OR Attorneys
4 = By Birthdate
5 = New Patients
6 = Labels for Patients
7 = Labels for Doctors OR Attorneys
8 = Labels for Insurance Carriers
9 = Labels for Payors
A = Archived Patients
B = Labels for Employers

The actual printing of the letters is accomplished through your word processing program, by merging the document you typed with the PTOSLETR.TXT file. The specific instructions used to create the merged letter will be dictated by your word processing program.

*****NOTE*** It is a common to have your word processing program loaded in a folder other than the folder where PTOS is located. If this is the case, there is one more step involved before the PTOS data can be merged with your letter. After selecting SEND LETTERS which creates the PTOSLETR.TXT file, PTOSLETR.TXT must be copied to the word processing subdirectory.**

DELINQUENT ACCOUNTS
Collection letters may be sent to overdue accounts by selecting option 1. PTOS will ask whether letters should be sent to patients with a balance over 30, 60, 90 or 120 days, and with no payments since a date you specify. You can also select a Account Type, Location or Office Number. PTOS also asks if you want the letters in patient name, number, or zip code order.

When you select DELINQUENT ACCOUNTS, the following fields are copied to a file called PTOSLTETR.TXT:

1 Patient Last Name	5 Payor Address Line 2
2 Patient First Name	6 Payor Address Line 3
3 Payor Name	7 Balance Due
4 Payor Address Line 1	8 Amount Overdue

SAMPLE OVERDUE ACCOUNTS LETTERS

July 31, 2005

[3]
[4]
[5]
[6]

We are very concerned about the status of the account for [2] [1]. Of the $[7] owed, [8] is more then 90 days past due. Frankly if you do not begin making payments immediately, we will be forced to take appropriate action!

Sincerely,
Imma Hardnose

DIAGNOSIS OR INJURY AREA
To send letters to patients with a specific diagnosis or injury area, select option 2, PTOS then asks for the diagnosis or injury area to locate. PTOS will search the patient Data File and find anyone with the appropriate diagnosis. You need only to specify part of the diagnosis. For example, entering **"BACK"** will result in any patient with the word **"BACK"** in their diagnosis being copied to the letter file. This would include those with **"BACK STRAIN"** or **"LOW BACK STRAIN".**

You can also select a specific Account Type, Location or Office Number. PTOS also asks if you want the letters generated in patient name, number, or zip code order. When you select DIAGNOSIS, these fields are copied to PTOSLETR.TXT:

1 Patient Last Name
2 Patient First Name
3 Address Line 1
4 Address Line 2
5 Address Line 3

SAMPLE DIAGNOSIS LETTER

July 31, 2005

[2] [1]
[3]
[4]
[5]

Dear [2]:
We are inviting all of our patients with back problems in for a FREE seminar on August 10th. If you're interested in attending please call for a reservation, as space is limited.

Sincerely,

W. E. Kair

DOCTORS OR ATTORNEYS

You may want to send letters to all referring physicians or attorneys, or to only those within a certain specialty, such as all neurologists. When you select this option, PTOS first asks if you want attorneys or doctors, and if you want only those with a certain specialty. If you want all doctors or all attorneys to receive the letter, just leave specialty blank. You can also indicate whether to generate the letters in name or zip code order. The following fields are then copied to PTOSLETR.TXT:

1 Last Name
2 First Name
3 Title
4 Address Line 1
5 Address Line 2
6 Address Line 3

BIRTHDATE

If you want to send birthday notes to patients, select this option. PTOS then asks for the birth month to find. If you want all patients born in June just type “06”. The same fields are copied as described in sending letters by DIAGNOSIS, above.

NEW PATIENTS

This option lets you send letters to all that were first seen within a date range that you select. One use would be to send **“welcome”** letters to all patients who started week. The same fields are copied as described in sending letters by DIAGNOSIS above, and can be generated in patient number, name or zip code order.

NOTE Each of the following label options allow you to select standard 3.5 inch by 15/16 inch (one across) labels or standard 1 inch by 2 5/8 inch (three across) labels. You can also enter a range of Zip Codes to include. If needed, you can adjust label alignment for your printer in SET PRINTER LINE FORMATS in CHANGE PARAMETERS.

LABELS FOR PATIENTS

If you want to generate labels for patients, load labels into your printer, and select this option. PTOS will then ask if you want to generate labels for a specific account type, location or office. You can also print for only patients with a FIRST VISIT date on or after a date you enter, and you

can select active, discharged, or all patients. You can print the labels in patient number, name or zip code order, and you can tell PTOS how many labels to print for each patient.

LABELS FOR DOCTORS OR ATTORNEYS
If you want to generate labels for referring doctors or attorneys, load labels into your printer, and select this option. PTOS will then ask whether to print for doctors or attorneys. You can also enter a **"specialty"** to print the labels for, or you can leave blank for all. The labels can be printed in name or zip code order, and you can specify how many labels to print for each doctor or attorney.

LABELS FOR INSURANCE CARRIERS
This lets you generate labels for one or a group of insurance carriers.

LABELS FOR PAYORS
If you want to generate labels for payors, load labels into your printer, and select this option. PTOS will then ask if you want to generate labels for a specific account type, location or office. You can also print for only patients with a FIRST VISIT date on or after a date you enter, and you can select active, discharged, or all patients. You can print the labels in patient number, payor name or zip code order, and you can tell PTOS how many labels to print for each payor.

ARCHIVED PATIENTS
This option lets you send letters to patients who have been removed from the active data files. The same field formats are used as described in DIAGNOSIS letters above.

LABELS FOR EMPLOYERS
This lets you print labels for an employer or group of employers.

SCHEDULING AND SUPERBILLS
This option allows you to schedule patient visits, review schedules and print superbills (or charge tickets) for patients who are scheduled. When this task is selected, the menu on the next page appears.

SCHEDULING AHD SUPERBILLS
1 = View & Update Schedule
2 = Print New and Modified Entries
3 = Print Schedule Lists
4 = View Schedule for a Patient
5 = Print Schedule for a Patient
6 = Print Superbills
7 = Maintain Schedule File

7- MAINTAIN SCHEDULE FILE
Before you can start entering patients into the schedule, there are some setup procedures that must be performed. We'll start by covering the Maintain Schedule File options.

MAINTAIN SCHEDULE FILE
1 = ADD A NEW MONTH
2 = DELETE A MONTH
3 = RESET SCHEDULE FILE
4 = SET TIME PERIODS
6 = REMOVE A PATIENT SCHEDULE
7 = LIST SCHEDULED MONTHS

ADD A MONTH
You must create a monthly schedule for each therapist that will use the system. When you select option 1, you are asked for the two digit therapist code to schedule and the month to create the schedule for. PTOS then creates a schedule with forty-four time slots for each day of the month you've selected. Repeat this for each therapist, in each month you wish to schedule. If the month's schedule has already been created for the therapist, PTOS warns you and won't let you duplicate it. If the therapist does not already have any schedule, PTOS tells you, in case you are accidentally scheduling an invalid therapist code.

DELETE A MONTH
Each therapist monthly schedule takes up about 100KB of disk space. It then is important to free up space when possible. You can not have more than six months scheduled for any one therapist. If, for example, you had January through June scheduled for therapist GM, January would have to be deleted before July can be added. To delete a month, select this option, enter the month to delete, and PTOS lets you select a specific therapist or you can delete the entire month for all therapists.

RESET SCHEDULE FILE
As with other PTOS data files, the Schedule File should be reset weekly to keep it in its most efficient format.

SET TIME PERIODS
We supply a standard schedule format for time slots. This can and should be modified for your practice. To modify time periods, select this option and the screen on the next page will appear.

SET TIME PERIODS
ENTER THEREAPIST CODE OR "XX" FOR DEFAULT FORMAT TO SET

To change your default settings enter "XX" and the standard time periods shown on the next page will be shown for editing. You can then go through and enter your own time slots. This "XX" code is now your default format. You can further customize the schedule for each therapist by enter the therapist code and changing time slots as needed.

*****NOTE*** TIME PERIODS MUST BE SET FOR EACH THERAPIST BEFORE YOU CAN SCHEDULE PATIENTS FOR THAT THERAPIST. THIS IS TRUE EVEN IF THEY WILL USE THE "DEFAULT" FORMAT. You may view data for more than one therapist on the same screen, as explained under VIEW AND UPDATE SCHEDULE. HOWEVER, time slots SHOWN will be for the first therapist listed.**

To block out time for a therapist, select this task. Enter the date, therapist code, time slots to block and a description. The "block description" will then be filled out in the patient name field for each of the slots. This could be "LUNCH", "MEETING" or any other use. Patient number is assigned "XXXXXX" for these blocked out slots, so if you wish, you can run Schedule Lists for patient "XXXXXX" to see what has been blocked.

BLOCK OUT TIME SLOTS
ENTER DATE
ENTER THERAPIST CODE
ENTER SLOT 1SLOT 2 SLOT 2 SLOT 3 SLOT 4
ENTER BLOCK DESCRIPTION

REMOVE A PATIENT SCHEDULE
Sometimes you may have a series of appointments scheduled for a patient and that patient drops out of therapy. You can clear the patient out of the schedule by selecting this task and entering the patient account number.

LIST SCHEDULE MONTHS
As mentioned above, the schedule file will hold six months of scheduling for each therapist. Select this option to see what is in the file and what can be cleared out.

1 -VIEW & UPDATE SCHEDULE
Once therapist schedules have been created, option 1, and the following screen appears:

VIEW AND UPDATE SCHEDULE
THERAPSITS TO VIEW: THERAPIST 1
THERAPIST 2
THERAPIST 3

DATE TO VIEW 2005/08/01

FORMAT: 1), 2), PR 3), COLUMNS 2

In addition to the date to view, you can select the column format and which therapists to view. The default is a two column format. If you entered GM as Therapist 1, the following will appear:

```
SCHEDULE FOR 05/08/01 THERAPIST GM
 #   TIME PAT#   NAME           VS RM:#  TIME PAT#  NAME                    VS RM
01   8:00                            :23 1:30
02   8:15                            :24 1:45
03   8:30                            :25 2:00
04   8:45                            :26 2:15
05   9:00 1001AR Roberts, Alex  E2 2 :27 2:30
06   9:15    "      "                :28 2:45
07   9:30                            :29 3:00
08   9:45                            :30 3:15
09  10:00 1002TS Salmon, Tom    G3 1 :31 3:30
10  10:15                            :32 3:45
11  10:30                            :33 4:00 1034HR Robinson, Harry         T1  1
12  10:45                            :34 4:15
13  11:00                            :35 4:30
14  11:15                            :36 4:45
15  11:30                            :37 5:00
16  11:45                            :38 5:15
17  12:00 STAFF MEETING              :39 5:30
18  12:15   "    "                   :40 5:45
19  12:30   "    "                   :41 6:00
20  12:45                            :42 6:15
21   1:00                            :43 6:30
22   1:15                            :44 6:45
N)ext P)revious E)nd OR ENTER SLOT # TO UPDATE
```

The above shows the schedule for August first for George Moore. He has patients scheduled at 9, 10, and 4, and a staff meeting at noon. At the bottom of the screen, PTOS asks if you want to skip to the next day, move backward to the previous day, or you can enter the time slot to update. If you enter time slot 21, the following screen appears:

UPDATE SCHEDULE
DATE 2005/08/01 THERAPIST GM TIME SLOT 21
PATIENT NUMBER
PATIENT NAME
NOTES
VISIT CODE
ROOM NUMBER

You can fill in the patient number, or use the HELP KEY to find the patient. If the patient has already been entered into PTOS, their name is automatically filled in. If the patient isn't already in the system, you can type in the name. You could also enter a description such as STAFF MEETING to block out a time slot. You can also enter any notes about the patient and a Visit Code and Room Number. Visit Codes can be established by you such as E3 for a thirty minute eval or E6 for a one hour exercise session.

The example above shows a two column display. If you select a one column display, either the morning or afternoon schedule will appear, including the NOTES field. If a three column display is selected, The morning or afternoon schedule for three consecutive days is shown.

If you wish to see the schedule of two or three therapists at the same time, enter the three therapist codes and the column format automatically changes to 3. In each column, instead of different days as shown above, you will see the morning or afternoon schedule of the three therapists for the day you've selected.

MODIFYING THE SCHEDULE
If you need to change a time slot, perhaps a patient canceled or needs to be changed, just select the time slot to update, and space (or press CTRL + "Y") to delete the patient name, number and notes.

2 -PRINT NEW AND MODIFIED ENTRIES
After you've added to the schedule or modified existing entries, the changes can be printed on an audit list similar to the Daily Transaction Report. When you select this option, the following screen appears, allowing you to choose the most useful printout format.

PRINT NEW AND MODIFIED ENTRIES

SORT LIST BY
1 = THERAPIST
2 = PATIENT NUMBER
3 = PATIENT NAME
4 = DATE
5 UNSCHEDULED PATIENTS
ENTER SELECTION

ENTER LOCATION OR LEAVE BLANK FOR ALL
ENTER OFFICE # OR LEAVE BLANK FOR ALL
ENTER THERAPIST OR LEAVE BLANK FOR ALL

ENTER FIRST DATE
ENTER LAST DATE

4 - VIEW SCHEDULE FOR A PATIENT
All appointments scheduled for a specific patient can be viewed at any time.

5 - PRINT SCHEDULE FOR A PATIENT
If a **"hard copy"** is needed, for example, hand the patient their schedule for the next two weeks, this task can be selected.

6 -PRINT SUPERBILLS

Superbills (or charge tickets) can be printed for any day for which patients have been scheduled. Normally, these will be printed first thing in the morning for patients scheduled that day. The format for superbills is shown on the next page.

PTOS prints the patient number and name, the date of treatment, therapist code, account type and co-pay amount on the first line. The second line shows the current account balance, and primary diagnosis. If you wish, a Bar-Code patient number can print in place of the regular patient number. You can select printing, one, two or three superbills per "11 inch page". The default is three patients per 66 line page (each super bill would be 3.666 inches). This is the format shown on the following page. You can have custom forms printed to align with this format, listing your procedures and charges, and any other desired wording.

1010RT TRERASSAS, ROBERT 2005/07/31 GM MC 5.00
2052.63 MALIGNANT NEOPLASM OF BONE

1021GS SMALL, GEORGE 2005/07/31 A1 10.00
131.12 INTRASPINAL ABSCESS OR DISC SPACE INFECT

1231NR RESTON, NANCY 2005/07/31 B1

REMOVE OLD ACCOUNTS
Periodically, you should purge your patient files. This will free up space on the computer, and enable the system to operate more efficiently. If the patient's data will not be needed for future MANAGEMENT REPORTS, the account can be REMOVED. To mark an account to remove, the balance must be "zero" and a discharge date must be entered. You then enter an **"A"** in the EDIT field of the patient's account. At the end of a month, or any other time frame, select the REMOVE OLD ACCOUNTS option, and the following menu appears.

INACTIVE ACCOUNTS

1 = MARK ACCOUNTS TO REMOVE
2 = LIST ACCOUNTS TO REMOVE
3 = REMOVE OLD ACCOUNTS
4 = LOST REMOVED ACCOUNTS

1 -MARK ACCOUNTS TO REMOVE
Instead of marking individual accounts, selected, the following menu appears:

MARK ACCOUNTS TO BE REMOVED

INACTIVE IF DISCHARGE DATE IS PRIOR TO
INACTIVE IF LAST VISIST DATE PRIOR TO
INACTIVE IF LAST PAYMENT DATE PRIOR TO

All accounts in the date range you've specified are marked with an **"A".**

2 -LIST ACCOUNTS TO REMOVE
After marking accounts, you can run a list of who will be removed for verification.
3 - REMOVE OLD ACCOUNTS
All accounts you've marked with an "A" will be PERMANENTLY removed.

4 -LIST REMOVED ACCOUNTS
This will print a reference list of which accounts have been removed.

RENUMBER ACCOUNTS
You may occasionally need to renumber a patient account or change an insurance carrier code. You may also want to copy patient demographic data to a new account. This task allows you to do so. Choose the desired operation from the following menu:

RENUMBER PATIENT ACCOUNTS & OTHER CODES

1 = RENUMBER PATIENT ACCOUNT
2 = COPY PATIENT ACCOUNT
3 = RENUMBER INSURANCE CODE
4 = COPY PATIENT ACCOUNT TYPE TO TRANSACTION ACCOUNT TYPE

If you select option 1, you are asked for the current patient account number, and the new number you want it changed to. The patient account and all transactions for the patient are then renumbered.

Option 2 asks for the current account number and the new account number that you want the patient data copied to.

If option 3 is selected, you are prompted to enter the current insurance code and the desired code. The code is then changed in the insurance file, and ALL PATIENTS THAT HAVE THE CURRENT CODE ENTERED AS EITHER THEIR PRIMARY OR SECONDARY INSURANCE, WILL HAVE IT REPLACED WITH THE NEW CODE.

When a transaction is posted, the patient account type is entered as part of the data. If a patient's account type changes, the transaction account type is still shown as the original account type. Selecting option 4 lets you update the new patient account type into all transactions posted for a specific patient.

UPDATE TRANSFER FILES
This selection lets you interface PTOS with other programs such as scheduling or documentation programs supplied by other vendors, or with custom programs designed for you by APS. It will only be active if you have purchased such programs to interface with.

IMPORTED INSURANCE PAYMENT DATA
This selection will allow you to interface PTOS with our new EOB reader. If you have purchased the PTOS EOB reader, this option will allow you to import ERA files for posting insurance payments into PTOS.